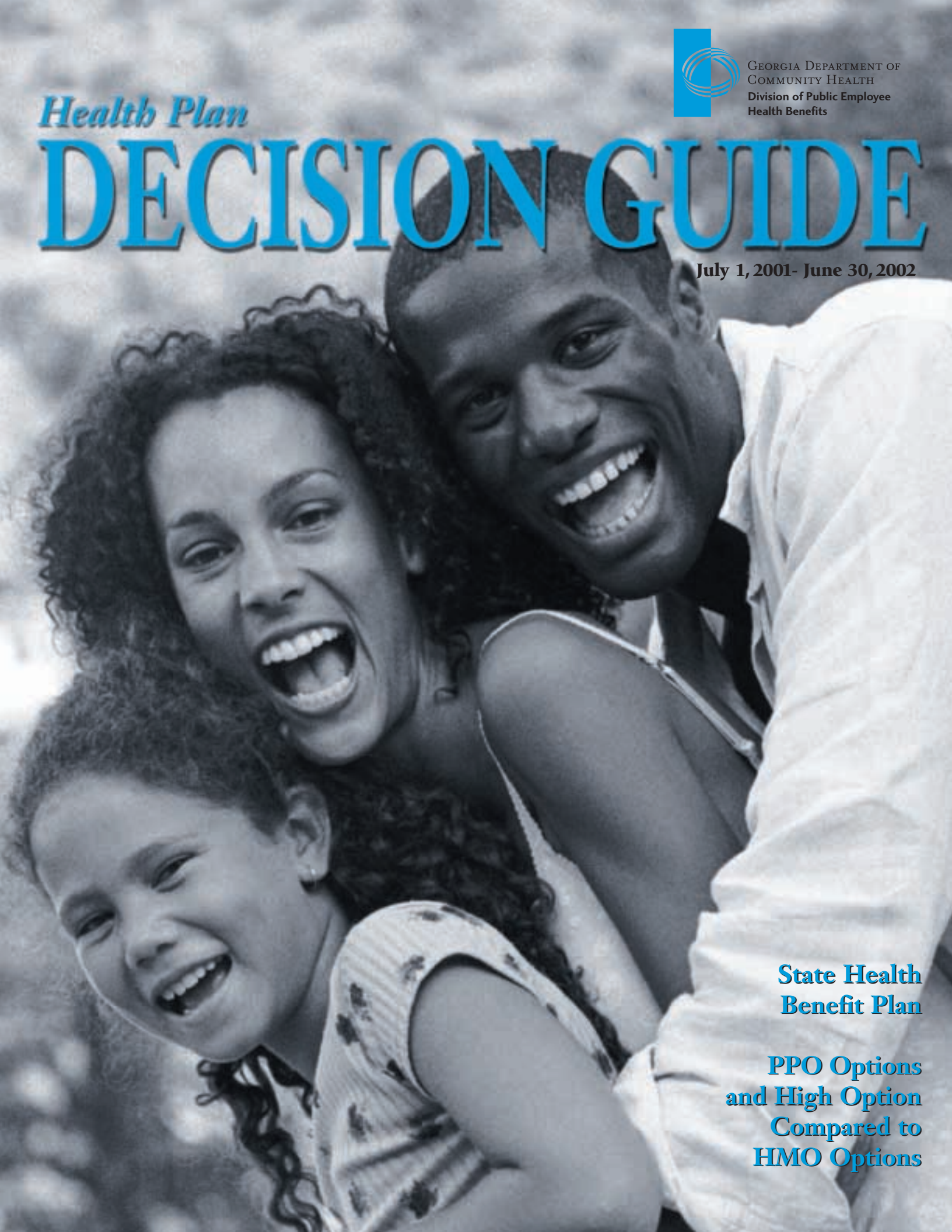


Georgia Department of Community Health
Division of Public Employee Health Benefits

Health Plan DECISION GUIDE

July 1, 2001- June 30, 2002

State Health Benefit Plan

PPO Options and High Option Compared to HMO Options

Benefit and Provider Information:

Health Plan DECISION GUIDE

PPO, PPO Choice and High Option

Pharmacy Benefit Program Information:
Contact Express Scripts at (877) 650-9342

PPO Option/PPO Choice Option

Benefit and Rate Information:
Contact your personnel/payroll representative

Online Georgia PPO Provider Information:
www.healthygeorgia.com

Online National PPO Provider Information:
www.healthygeorgia.com

If your personnel/payroll representative is not available, benefit information is available by calling member services at:
(800) 483-6983 (outside Atlanta) or
(404) 233-4479 (inside Atlanta)

During the open enrollment period, call volume for these numbers is expected to be very high, and you may experience time on hold.

TDD line for the hearing impaired: (404) 842-8073

PPO Choice Option (Only)

Nomination of PPO Provider Information:
(800) 483-6983 (outside Atlanta) or
(404) 233-4479 (inside Atlanta)

Nomination of BHS Provider Information: (800) 631-9943
TDD Line for the hearing impaired: (678) 319-3860

Nomination of Transplant Provider Information:
(800) 762-4535 (outside Atlanta) or
(770) 438-9770 (inside Atlanta)

High Option

Contact your Personnel/Payroll Representative:
If a representative is not available, call phone numbers given above for PPO Option benefit and rate information.

TDD line for the hearing impaired: (404) 842-8073

Aetna U.S. Healthcare

Regular HMO Option: (800) 444-0759
Consumer Choice Option: (800) 443-6917
Online Provider Information: www.aetnaushc.com

BlueChoice HMO

(800) 464-1367
Online Provider Information: www.bcbsga.com

Kaiser Permanente HMO

(404) 261-2590
Online Provider Information: www.kp.org/ga

Contents

Introduction:

Many employees who are covered by the State Health Benefit Plan (SHBP) have a choice between enrolling in an enhanced Preferred Provider Organization (PPO) option, enrolling in an indemnity option (the High Option), and enrolling in one of the Health Maintenance Organization (HMO) options that offer membership in parts of Georgia.

The SHBP has a number of coverage options

NEW! Effective July 1, 2001, the PPO will have a national network of preferred providers. Within the PPO and HMO options, you also have a "consumer choice" option. All Plan options are explained in detail in the next few pages. Please take a look at pages 36 through 37 of this booklet. If you find your county of residence or employment marked "Yes" under the name of an HMO, you're eligible to join that HMO. The PPO and High Options are available to all members regardless of your residence.

Which option is better for you and your family?

There's no easy answer to this question. However, be sure to consider the PPO Option since it combines the flexibility of provider choice with the added plus of low in-network office visit copayments, age-appropriate preventive care (see Preventive Care on page 24), out-of-state balance billing protection, and lower

premiums. While making your decision, be sure to consider your family's current and potential medical needs, how close your home is to medical facilities, your family situation, whether or not you have already established a relationship with a family physician, your opinion of preventive medical care, and various other factors.

These different options are offered to you and your family through the SHBP so that you'll have a chance to choose the best possible program of medical care, at a price that will fit into your budget. Note, however, that the PPO and the High Options are available to all members, but you must live or work in an HMO's service area to be eligible for that HMO.

The SHBP prepared this Guide to help you decide for yourself which option to choose. Read it thoroughly; compare the features of the options; and read about the advantages and disadvantages between PPO, High, HMO, and Consumer Choice option coverage.

The HMO provider directories in this Comparison of Benefits Package are dated and subject to change. Before selecting your doctor, call the doctor's office to make sure that he or she is accepting new patients.

PPO and HMO providers also are listed on respective Web sites. (See the inside front cover of this Guide for telephone numbers and Web site addresses.) If you don't have Internet access, you may call the member services numbers for each Plan option to see if any doctors were added or deleted since the directories were printed.

Note: The PPO provider directory is not included inside this package. For the most up-to-date listing of Georgia PPO Providers, visit the Georgia 1st/MRN Web site at *www.healthygeorgia.com.* If you do not have Internet access, see your personnel/payroll office to view a printed copy. Since the provider network changes continuously, and in order to conserve resources, only a limited number of printed directories will be available. For the most up-to-date listing of national PPO providers, visit *www.healthygeorgia.com* and click on the icon for national PPO (Beech Street) providers.

Description of Coverage Options

Effective July 1, 2001, the SHBP offers members up to nine different options for active employees. By carefully reviewing each option, you can select the coverage that best meets your needs.

The in-network benefits under the Standard PPO Option include age-appropriate preventive care, office visit copayments for preventive care and visits for illness or injury. For July 1, 2001, in-network PPO benefits have been enhanced to cover a broader range of wellness services. Also new for July 1, 2001, the prescription drug benefit in the Standard PPO, PPO Choice, and High Options has been changed to a copayment program — where you do not have to pay a deductible first and wait for reimbursement. see p.23.

We are also pleased to report that more than 3,500 doctors and 19 hospitals have been added to the Georgia PPO network since last year.

Last year the SHBP awarded a contract to MRN/Georgia 1st, a preferred provider organization, to manage a comprehensive network of providers at discounted rates in the Georgia area. These discounted rates allow the SHBP to expand your benefits while also reducing the cost of care.

This year, the SHBP awarded a contract to Beech Street Corporation to manage a comprehensive national network of providers outside the state. This national network gives PPO members balance billing protection and reduced out-of-pocket costs when using a participating national provider. The national network is effective on July 1, 2001. Be sure to see page 34 for points to consider about using national PPO providers.

The next few pages summarize each option.

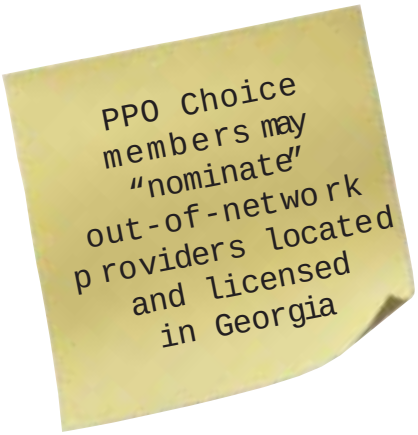
Standard PPO Option Description

The enhanced PPO consists of a network of participating doctors, ancillary providers, and hospitals that have agreed to provide quality medical care and services at discounted rates. You must use a participating network provider to receive the higher levels of benefit coverage. However, since lower, out-of-network levels of benefit coverage are available, you don't have to receive services from a participating network provider in order to receive coverage.

The PPO has many of the advantages of an HMO—plus a larger network of participating providers and the flexibility to go out-of-network and see a non-participating provider for your health care services at a lower level of benefit coverage. With your out-of-network benefits, you can see any health care provider you like, but with a greater financial responsibility. Whether you see a participating network PPO provider or a non-participating provider, you don't have to choose a primary care physician to direct your care. Benefit coverage under the PPO Options generally will be at one of three levels depending on where care is received: Coverage will be at the 90% level for in-network PPO services received in state and in the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama.

Some Advantages of the Enhanced Standard PPO...

- The PPO is available to anyone eligible for SHBP coverage.
- You have no claim forms to file when you use participating providers. Participating network providers submit claim forms for you.
- You are not responsible for any amounts above the Plan's allowed amounts when using participating PPO providers. Participating providers cannot "balance bill" members (See Definitions).
- You have access to participating network providers in selected areas, all across the United States. National PPO providers do not balance bill members.
- You get coverage for a wide range of in-network benefits, including annual check-ups, well-baby care, and immunizations.
- Copayments with no deductible for in-network office visits.
- Copayments with no deductible for covered prescription drugs.
- Lower out-of-pocket costs since coinsurance and deductibles are based on negotiated rates with participating providers.
- No in-network deductible to meet for preventive care. Preventive care coverage is based on age schedules and medical history; age schedules are available online at *www.healthygeorgia.com* or by calling member services. See Preventive (Wellness) Care on page 24.
- The enhanced PPO network includes a wide range of doctors representing all essential specialties, and includes most Georgia hospitals and selected hospitals across the country.
- You have the freedom to choose from the network of participating providers and receive the higher levels of benefit coverage, or to use out-of-network providers and receive a lower level of benefit coverage.
- You have out-of-service area coverage at the in-network benefit level for emergency and acute care. Balance billing is possible.



- You are not required to designate a primary care physician.
- You do not need a referral to see participating network specialists.
- You are not required to precertify care or get prior approvals when using participating Georgia providers. The Georgia PPO provider does this for you. However, this is your responsibility when using non-participating providers and national PPO providers.

Points to Consider about the PPO Option...

- In order to receive the highest level of benefit coverage, the PPO requires you to use the doctors and facilities that are in its network, including hospital-based physicians, laboratories, testing centers, and other ancillary providers. If you have a family doctor who isn't affiliated with the PPO, coverage for that doctor is available, but at the lowest level of benefit coverage.
- You may have to submit a claim form if you go out-of-network for services.
- When seeking medical care from participating network providers, it is your responsibility to check with the PPO to be sure that the provider is participating in the network. You will not receive the higher in-network PPO benefits unless the provider is participating in the PPO network. Also, you can be balance billed by providers who are not participating in the PPO networks.
- If you join a PPO Option, and your primary care physician or specialist leaves the network in the middle of a Plan Year, you won't be allowed to change options until your next open enrollment period, unless you have a qualifying event as described in your Plan documents. However, you may choose another in-network provider or you may still receive out-of-network benefits if you continue to see that provider.
- Some of the doctors affiliated with the PPO Option may not accept new patients at some times during the year. Check with the physician of your choice before you enroll in the PPO.
- Members must call the MCP to precertify out-of-network hospitalization and specified outpatient procedures.

PPO Consumer Choice Option Description

Eligible employees may select the PPO Consumer Choice Option (PPO Choice). In return for a higher premium, this option gives members the opportunity to request that an out-of-network provider be treated as an in-network provider. This request is known as a "nomination." Eligible providers include doctors, hospitals and other providers located and licensed in Georgia for which the PPO offers coverage. If the out-of-network provider accepts your nomination and meets the PPO's requirements, you will receive in-network benefits from that provider. (Note, however, that a provider who accepts your nomination and meets the PPO's requirements does not become a participating provider within the PPO network.) Providers may be nominated at any time during the year if you choose this option during open enrollment. All providers do not have to be nominated immediately upon enrollment.
If your provider does not accept your nomination, does not meet the

PPO's credentialing requirements, or does not accept the network fees, then services from that provider are covered at the lower, out-of-network benefit level. Additionally, you will be required to pay a higher premium—even if the provider elects not to participate or does not meet the PPO's requirements. SHBP rules do not permit a member to change benefit plan options when a nominated provider or the PPO rejects a nomination. For further details regarding the nomination process, please contact member services.

PPO Choice Option benefits are the same as in the Standard PPO Option; however, PPO Choice Option premiums are higher. The PPO Choice Option service area is the same as in the Standard PPO Option. Contact member services directly to find out more about the required paperwork and procedures to nominate a provider. The member service numbers are on the inside front cover of this booklet. **Note:** The Behavioral Health Services (BHS) provider and transplant provider networks are separate from the PPO provider network. To nominate BHS or transplant providers, call the telephone numbers listed on the inside front cover of this Guide.

High Option Description

The High Option is an indemnity-type benefit program. Coverage is available for medical care given by a qualified medical provider for the treatment of an illness or injury and covered preventive care. High Option members may select any provider they want, but may be balance billed by non-participating providers or for non-covered benefits. Generally, members receive the same coverage level regardless of the provider selected, subject to the Plan's allowed amounts for covered services.

The High Option has similar coverage levels when compared to in-network PPO benefits, but has a higher premium and less coverage for preventive care. High Option also has the same prescription drug copayment program as the PPO. The High Option is more expensive than all other Plan options.

Also, if you use an out-of-state hospital that does not have a contract with the SHBP, or see a physician in or outside of Georgia who is not in the Participating Physicians Program (PPP), you are subject to balance billing from that provider and could have additional financial responsibilities. Amounts balance billed do not count toward your deductible or out-of-pocket spending limits. You may contact your physician or member services to see if your doctor is in the PPP.

Points to Consider about the High Option...

- High Option is available to anyone eligible for SHBP coverage.
- Like the PPO Option, you are not required to select a primary care physician or get referrals to see specialists.
- Higher premiums than any other option.
- Deductibles for office visits, medical care, and hospitalization must be met before benefits are payable.
- Coverage is available for preventive lab work and tests, subject to allowed amounts and annual maximums. Office visits for preventive care are covered, subject to the general deductible and co-insurance.
- **Remember:** You may be "balanced billed" if your doctor is not part of the Participating Physicians Program (PPP) and he or she charges you more than what the Plan allows. Charges that are over the Plan's allowed amounts are the member's responsibility and do not apply to the Plan's stop-loss limits and deductibles.
- Hospitals that do not contract with the SHBP also may balance bill for charges exceeding the Plan's allowed amounts. At present, all general hospitals in Georgia are under contract with the SHBP.
- You must precertify certain outpatient procedures and inpatient stays at non-participating hospitals. Financial penalties apply if precertification rules are not followed.

The "choice" option, as described for the Standard PPO and HMO options, does **not** apply to the High Option.

HMO Option Description

An HMO is an organization that seeks to maintain the health of its members (thus the name *health maintenance organization*) by delivering comprehensive medical care on a pre-paid basis.

Qualities that make the HMO Option different from Standard PPO Option coverage:

- In most cases, the HMO does not offer any coverage outside of the HMO's provider network. However, the PPO does offer coverage at a lower level of benefit coverage if non-emergency or non-acute services are received outside of the PPO's provider network.

- HMOs require the selection of a primary care physician (PCP) and, in most cases, a referral by the PCP is required for coverage of specialty care. The PPO does not require members to select a PCP or obtain referrals for specialty care.

- HMOs generally have no deductibles, coinsurance, or lifetime benefit maximums; however, the PPO Option does have deductibles, coinsurance and lifetime benefit maximums.

Qualities that make the HMO Option different from High Option coverage:

- The HMO emphasizes preventive health care. Periodic checkups are offered at little or no cost. The HMO approach is to find and correct health problems before they become bigger—and potentially more expensive.

- Membership in an HMO is pre-paid. A basic monthly premium takes care of the bulk of future expenses. Later expenses might include a *copayment*—for example $10-$15 for an office visit. But your monthly payroll deduction covers most treatment.

HMO Models- There are two HMO models...

1) **The Group-Practice (GP) model** HMO operates free-standing health centers within a service area. Some of these HMOs also may offer additional provider access through affiliated community physicians, making it more convenient for you to see your doctor. You choose among the physicians who practice in a health center or who are affiliated with the HMO. If your doctor decides you need to be hospitalized, he or she will refer you to a contracted hospital. There you'll be given covered medically necessary care, including the services of specialists—all monitored by your HMO physician.

2) **The Individual-Practice Association (IPA) model** HMO operates under the terms of a contract with individual practicing physicians. Each IPA doctor maintains a private practice, treating HMO members there and billing the HMO for his or her services to members. If your doctor decides you need hospitalization, you'll be referred to an institution that contracts with the HMO—and where your HMO physician has admitting privileges. There you'll be given covered medically necessary care, including the services of specialists—all monitored by your HMO physician.

If you join an HMO, you (and each covered member of your family) must select a primary care physician. You'll choose from a list of HMO-affiliated *participating* physicians in private practice, or among HMO-paid staff physicians who practice from the HMO's own health care center. From that point on, each family member's health care will be coordinated by his or her own primary care

physician. Generally, you'll find that HMOs utilize hospitalization only when inpatient care is medically necessary.

Some Advantages of the HMO Option...

These are some of the advantages an HMO can give you and your family:

- You'll have low-cost access to the many services the HMO offers in preventive health care—well-baby and well-child care, physical exams, and immunizations. Access to wellness programs is also available—health education, smoking cessation, weight loss, etc.
- Generally, you won't have to file any claims. Paperwork usually enters the picture only for services received outside the HMO's service area.
- In most cases, HMOs do not have deductibles to meet—so your out-of-pocket costs may be lower.
- You'll know in advance how much your cost for a visit or treatment is going to be.
- There are no preexisting condition limitations or lifetime benefit maximums.

Points to Consider about the HMO Option...

HMO membership is not for everyone. Here are some of the negative factors to consider:

- All HMOs require you to use the doctors they employ or contract with; some require you to use their health center facilities. Other than for emergency care or acute care, you will receive no benefits outside the HMO network. If you have a family doctor who isn't affiliated with an HMO, joining an HMO would force you to end that relationship and choose another physician.
- You may be required to follow the HMO's standardized treatment plan for your condition. For example, you may be required to receive treatment from your primary care physician for a specified period before getting a referral to see a specialist.
- If you join an HMO and your primary care physician or specialist decides to leave the HMO in the middle of a Plan Year, you won't be allowed to leave the HMO or to change options until your next open enrollment period.
- An HMO's facilities—doctor's office or health center, laboratory, contracted hospital(s)—may be inconvenient for you to visit.
- Some of the doctors affiliated with an HMO may not accept new patients at various times. Check with the physician of your choice before you enroll in the HMO.
- Most HMOs require you to get a referral from your primary care physician before you visit most specialists—an allergist, orthopedist, or cardiologist, for example. Failure to obtain a referral could result in a denial of your claim.
- You must live or work in the HMO's service area in order to have coverage under that HMO. If you—or your dependent(s)—do not live in the HMO's service area, then your eligibility for coverage (or that of a dependent) may be affected. Be sure to contact the HMO ahead of time to see what coverage is available, if any, outside the service area.

HMO Consumer Choice Option Description

Eligible employees may select one of the "consumer choice" options offered by each HMO in the SHBP. In return for a higher premium, the HMO Consumer Choice Option gives members the opportunity to request that an out-of-network provider be treated as an HMO network provider. This request is known as a nomination. Eligible providers include doctors and hospitals and other providers through which the HMO offers coverage.

If the out-of-network provider accepts your nomination and accepts the HMO's requirements, you may receive in-network benefits from that provider. If your provider does not accept your nomination, does not agree to the HMO's requirements, or does not accept the HMO's fees, then services from that provider are not covered. SHBP rules do not permit a member to change options when a nominated provider or the HMO rejects a nomination.

HMO Consumer Choice Option benefits are the same as in the respective regular HMO Option; however, HMO Consumer Choice Option premiums are higher. Premium information is available from your personnel/payroll office. Please contact the HMO directly to find out more about the required paperwork and procedures to nominate a provider.

Five Steps
To Safer Health Care:

1. Speak up if you have questions or concerns. Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

2. Keep a list of all the medicines you take. Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. Make sure you get the results of any test or procedure. Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected — in person, on the phone, or in the mail – don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4. Talk with your doctor and health care team about your options if you need hospital care. If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5. Make sure you understand what will happen if you need surgery. Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

Consumer Messages on Patient Safety
Source: The Quality Interagency Coordination Task Force (QuIC)

Definitions:

Acute Care: *Care provided when such services are medically necessary and immediately required as a result of a sudden onset of illness or injury.*

Allowed Amount: *A dollar figure the Plan uses to calculate benefits payable. For example, in the Standard PPO, the allowed amount is based in part on the network rate.* ***Plan members using non-network providers (PPO Option) or non-participating providers (High Option) are responsible for paying any amount charged over the allowed amount.*** *PPO members using network providers are charged only up to the allowed amount and will not be subject to additional payment for that service.*

Ancillary Providers: *Suppliers of covered medical services and procedures, including but not limited to ambulance services, durable medical equipment suppliers, chiropractors, home health and hospice care services and physical therapists.*

Balance Billing: *A dollar amount charged by a provider that is over the Plan's allowed amount for the care or treatment received. Amounts balance billed are the member's responsibility and do not apply to the Plan's stop-loss limits or deductibles. PPO providers do not bill for amounts over the allowed amounts, so members will not be subject to balance billing when using a network PPO provider. However, PPO members are subject to balance billing when using an out-of-network provider. High Option members may be balance billed by physicians who do not participate in the Participating Physicians Program and by hospitals that do not have a direct contract with the state.*

Behavioral Health Services (BHS): *The BHS program is a part of the PPO and High Options. It is a managed care program for mental health and substance abuse benefits. The program is designed to provide wide access to necessary care while balancing choice of provider, enhanced benefits within the network, and overall cost effectiveness. In order to receive full benefits, members must contact BHS prior to receiving behavioral health services.*

Brand-name Drug: *A drug that is advertised and sold using a trade name that is protected by patents so that it can be produced only by one pharmaceutical manufacturer for a pre-determined number of years.*

CCO: *Consumer Choice Option.*

CCU: *Coronary-care unit.*

Coinsurance: *A percentage of the provider's charge or the Plan's allowed amount that must be paid by the member for covered benefits and services, generally 10% to 40%. Coinsurance is applied toward deductibles and stop-loss limits.*

Copayment: *A fixed dollar amount that must be paid by the member for a particular service or item at the time it is received; for example, $10 or $20 for office visits. Copayments do not apply toward deductibles or stop-loss limits.*

Custodial Care: *Assistance with the routine activities of daily living (bathing, dressing, eating, etc.), or running errands for the patient. Generally, care is considered custodial if it can be provided by an untrained adult with little or no supervision.*

Deductible: *A fixed dollar amount that must be paid out-of-pocket by the patient before any benefit is payable by the patient's health care plan. Paid each Plan Year and, in some cases, paid per hospital admission, depending on your coverage option.*

Disposable Supplies: *Medical supplies of a non-durable nature that are not intended for repeated use; that are used primarily for a medical purpose; and that are appropriate for use in a patient's home—for example, diabetic supplies (test strips, syringes,lancets, etc.) and ostomy supplies.*

Durable Medical Equipment: *Medical supplies of a non-disposable nature that can withstand repeated use; that are used primarily for a medical purpose; that generally are not useful to a healthy person; and that are appropriate for use in a patient's home— for example, crutches or a wheelchair.*

Emergency Care: *Care provided in the event of a sudden, severe and unexpected illness or injury which, if not treated immediately, could be life-threatening or result in permanent impairment of bodily functions.*

Generic Drug: *A drug for which the patent has expired, allowing other manufacturers to produce and distribute the product. Generics are essentially a chemical copy of their brand-name equivalent. The color or shape may be different, but the active ingredients must be the same for both. Companies that produce generic equivalents are required to follow stringent FDA regulations for safety.*

High Option (H/O) Rate: *The dollar amount used in determining an allowed amount in the High Option, which is determined by the SHBP and based in part on contracted rates.*

Hospital-based Physicians: *Anesthesiologists, emergency room physicians, pathologists, and radiologists.*

ICU: *Intensive-care unit.*

Indemnity Plan: *A health plan model allowing members freedom to select providers and to direct their own care. The High Option is an indemnity-type plan, which includes a network of participating providers that may not balance bill members.*

Institutional Charges: *Expenses incurred in and billed by a hospital or ambulatory surgical center.*

Medical Certification Program (MCP): *The MCP is a part of the PPO and High Options. It is designed to help members and the Plan save money by preventing unnecessary care. To avoid a reduction in benefits, you must comply with the MCP requirements outlined in Plan documents.*

Non-preferred Brand-name Drug: *(For Standard PPO, PPO Choice, and High Option members.) A brand-name drug that is not on the Plan's preferred drug list.*

OB/GYN: *Obstetrician and gynecologist.*

Out-of-Network (OON) Rate: *The dollar amount used in determining an allowed amount in the Standard PPO Option and PPO Choice Option when non-participating providers are used, which is based in part on the network PPO rate.*

Participating Physician Program (PPP): *(The PPP only applies to High Option members). A contractual arrangement between the Plan's claims administrator, Blue Cross and Blue Shield of Georgia Inc., and medical doctors who practice in Georgia. Each participating physician agrees to accept the Plan's allowed amount for his or her services and may not balance bill members. (Participating PPO providers also agree to accept the Plan's allowed amount and may not balance bill members.)*

Plan Year: *July 1st through June 30th of the following year.*

Preferred Brand-name Drug: *(For Standard PPO, PPO Choice, and High Option members.) A brand-name drug that is on the Plan's preferred drug list.*

Preferred Drug List: *(For Standard PPO, PPO Choice, and High Option members.) A list of drugs that is created, reviewed, and continually updated by a team of physicians and pharmacists. The preferred drug list contains a wide range of generic and preferred brand-name products that have been approved by the FDA. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.*

Preferred Provider Organization (PPO): *The PPO consists of a comprehensive network of doctors, ancillary providers, and hospitals that have agreed to offer quality medical care and services at discounted rates. You must use a participating network provider to receive the highest level of benefit coverage. If you choose a PPO, you have the flexibility to go out-of-network for your health care services and receive a reduced level of benefit coverage. With your out-of-network benefits, you can see any qualified provider of medical services. You pay a greater percentage of the charges for covered services if you go out-of-network and you are subject to balance billing for charges above the Plan's allowed amounts.*

Primary Care Physician (PCP): *A doctor who has the primary responsibility for providing, arranging and coordinating every aspect of a patient's health care. An HMO member must select a PCP. PPO members are not required to select a PCP. Generally, PCPs are either internists, family practitioners, pediatricians, or OB/GYNs.*

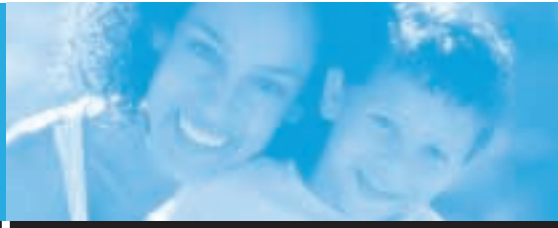
Provider: *Licensed medical doctors, hospitals, and other health care providers through whom the PPO, High, or HMO offers coverage.*

Self-insured Benefit Plan: *A program of medical care reimbursement in which an employer and its employees pay all costs of employee health care; no outside insurance company underwrites the risk or makes a profit. The High Option and PPO Options are examples of self-insured benefit plans.*

Service Area: *A service area consists of approved counties or geographic areas in which in-network services are available.*

Stop-loss Limit: *A maximum annual dollar amount that a Plan member would have to pay out-of-pocket for covered expenses. Once the stop-loss limit is reached, covered expenses for the remainder of the Plan Year are reimbursed at 100%. Stop-loss limits are available per person and per family.*

Summary of Coverage Options Chart



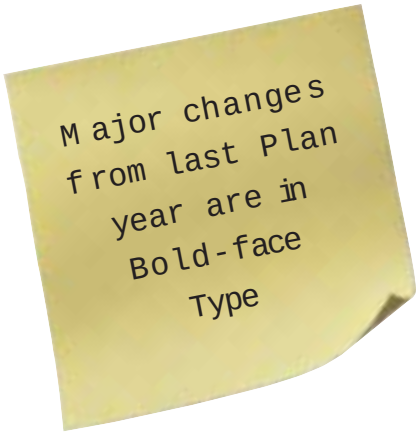
PPO Options (Two Options)	HMO Options (Six Options)	High Option (One Option)
Standard PPO Option	***Regular HMO Options***	
• Available to anyone eligible for SHBP coverage.	• The SHBP has three different regular HMO Options, each offering different benefits. HMO coverage availability varies by HMO and you must live or work in the approved HMO service area to be eligible for their coverage.	• Available to anyone eligible for SHBP coverage.
• You can choose providers who participate in the network and receive a higher level of benefit coverage. You can choose out-of-network providers and receive a lower level of benefit coverage.	• You receive coverage when in-network providers are used for covered services. In most cases, services are not covered outside of the HMO's provider network.	• Except for behavioral care and transplants, coverage levels are not based on a provider's network participation. Non-participating providers may balance bill.
• You are not required to select a primary care physician and referrals are not required to see specialists.	• You are required to select a primary care physician and in most cases referrals are required to see specialists.	• You are not required to select a primary care physician and referrals are not required to see specialists.
• For selected services, you must meet deductibles before benefits are payable.	• Generally, there are no deductibles to pay.	• You must meet deductibles before most benefits are payable.
• In-network office visit copayments. Office visit copayments are not subject to a deductible.	• In-network office visit copayments.	• Office visit copayments are not available. Charges are subject to deductibles and coinsurance amounts.
• You have in-network coverage for age-appropriate preventive care, including coverage for office visits.	• You have in-network coverage for preventive care, including coverage for office visits.	• You have coverage for age appropriate preventive care, including coverage for office visits.
• You have in-network coverage available from participating out-of-state providers in selected areas across the country.	• Coverage out-of-state is generally restricted to acute and emergency care.	• You have coverage for out-of-state providers; however, charges over allowed amounts are balanced billed, if services are from non-participating providers
PPO Consumer Choice Option	***HMO Consumer Choice Options***	• A "consumer choice" option does not apply to the High Option.
• Available to anyone eligible for SHBP coverage. Only providers located and licensed in Georgia may be nominated.	• Each of the three regular HMO Options has a respective HMO Consumer Choice Option. Eligibility rules are identical to the regular HMO Option.	
• Benefits are identical to Standard PPO benefits.	• Within the respective HMO, benefits are identical to regular HMO Option benefits.	
• Higher premiums than Standard PPO Option coverage.	• Higher premiums than respective regular HMO Option coverage.	
• Contact member services to get details on the paperwork required to nominate a provider.	• Contact the HMO to get details on the paperwork and procedures required to nominate a provider.	
• You may nominate an out-of-network provider located and licensed in Georgia to be treated as a PPO network provider. The provider must accept your nomination, meet the PPO's requirements, and accept the fee schedule before in-network coverage is available. **If the provider nomination is rejected, out-of-network benefit coverage is available from that provider.**	• You may nominate an out-of-network provider located and licensed in Georgia to be treated as an HMO network provider. The provider must accept your nomination, meet the HMO's requirements, and accept the fee schedule before in-network coverage is available. **If the provider nomination is rejected, services from that provider are not covered.**	

Comparison of Benefits for the PPO Options, the High Option, and the HMO Options

On the following pages, you will find a comparison of benefits for each coverage option currently available under the State Health Benefit Plan. This Guide's purpose is to give you a general description of each option and a basis for comparing the major features.

Contact the member services unit of each option directly for more details (telephone numbers are on the inside front cover). Also, see the SHBP booklet titled *State Health Benefit Plan*, November 1, 1995, and the UPDATER newsletters published afterwards. Booklets and UPDATERs are available in your personnel/payroll office.

Important Notes:



- Deductibles and benefits with annual dollar or visitation limits under the PPO and the High Options are based on the State's fiscal year. The State's fiscal year starts on July 1 and ends on June 30 of the following year. This period is also known as the "Plan Year."
- Since "consumer choice" option benefits are the same within each HMO and the PPO Option, a separate listing of benefits is not included in the following chart. The Consumer Choice Option for each HMO is identified by using the HMO's name followed by the letters "CCO." The PPO Consumer Choice Option is from hereon referred to as "PPO Choice."
- Even though each option listed in this Guide provides a broad range of benefits, you should be sure those benefits are compatible with your current personal/family needs. If you have specific coverage needs not addressed in this summary booklet, then call the appropriate member services number for assistance. See inside front cover for phone numbers.
- NEW! Major benefit changes from last year are in **bold-face** type for each option described in the following comparison chart.

Options /Service Area	**Description of Plan**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia **IN-NETWORK BENEFITS** Out-of-State	The PPO (preferred provider organization) consists of a comprehensive network of doctors, ancillary providers, and hospitals that have agreed to offer quality medical care and services at discounted rates. You must use a network provider to receive the highest level of benefit coverage. Generally, when you see a participating Georgia provider, your level of benefit coverage is 90% of the allowed amount and when you see a participating national provider, your level of benefit coverage is generally 80% of the allowed amount. The PPO Option is available to anyone eligible for SHBP coverage.
OUT-OF-NETWORK BENEFITS All Areas	If you choose a PPO, you have the flexibility to go out-of network for your health care services and receive a lower level of benefit coverage. Generally, when you see an out-of-network provider, your level of benefit coverage is 60% of the allowed amount for non-acute or non-emergency care. With your out-of-network benefits, you can see any qualified provider of medical services. You pay a greater percentage of covered charges for non-acute and non-emergency services if you go out-of-network and you are subject to balance billing for charges above the Plan's allowed amounts. Balance billing also is possible for acute and emergency services performed by an out-of-network provider.
HIGH OPTION All Areas	A benefit program that provides reimbursement, as described, for the costs of medical care rendered by a qualified professional provider of medical services for treatment related to an illness or an injury and for covered preventive care. While you have the flexibility to receive care by any qualified health care professional, you may be balance billed for charges over the Plan's allowed amounts when you use a non-participating provider. The High Option is available to anyone eligible for SHBP coverage.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	An Individual Practice Association (IPA) health maintenance organization that provides access to comprehensive medical services by private practice physicians who contract with Aetna U.S. Healthcare. All care must be provided or arranged for by an Aetna U.S. Healthcare physician, unless there is a life-threatening emergency.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	An IPA health maintenance organization that provides comprehensive medical services, out of individual private practice physician offices. All care must be provided or arranged for by a BlueChoice HMO provider, unless there is a life-threatening emergency.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	A Group Practice (GP) health maintenance organization with additional community physicians that provides various medical services as described. All care must be provided or arranged by a medical center physician, or an Affiliated Community Physician, unless there is an emergency. All references to Kaiser Permanente physicians include medical center and Affiliated Community Physicians.

Options / Service Area	**Description of Key Features**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	90% coverage for eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: $300 per person with a $900 family maximum. (BHS and transplant services are subject to an additional $100 hospital deductible. See Behavioral Health Services.) Physician office visits subject to office visit copayments. 100% coverage for eligible preventive lab work and tests, up to $500 per Plan Year with no deductible. **Three-tier copayment program for covered prescription drugs.** Stop-loss limits the deductibles and coinsurance to $1000 of eligible out-of-pocket expenses per person, or $2000 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. *Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits. Payments made toward deductibles and stop-loss limits do not count toward in-network/out-of-state or out-of-network deductibles and stop-loss limits. Lifetime benefit maximums are combined totals for PPO and High Option. Some annual maximums are combined with in-network/out-of-state and/or out-of-network benefits.*
IN-NETWORK BENEFITS Out-of-State	**80% coverage for eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: $400 per person with a $1200 family maximum. (BHS and transplant services are subject to an additional $100 hospital deductible. See Behavioral Health Services.) Physician office visits subject to office visit copayments. 100% coverage for eligible preventive lab work and tests, up to $500 per Plan Year with no deductible. Three-tier copayment program for covered prescription drugs. Stop-loss limits the deductibles and coinsurance to $2000 of eligible out-of-pocket expenses per person, or $4000 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted.** *Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits. Payments made toward deductibles and stop-loss limits are combined with out-of-network deductibles and stop-loss limits.*
OUT-OF-NETWORK BENEFITS All Areas	60% coverage for eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: $400 per person with a $1200 family maximum. (BHS and transplant services are subject to an additional $100 hospital deductible. See Behavioral Health Services.) 60% coverage for eligible physician office visit charges after deductible. Preventive care not covered. **Three-tier copayment program for covered prescription drugs.** Stop-loss limits the deductibles and coinsurance to $2000 of eligible out-of-pocket expenses per person, or $4000 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. *Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits. Payments made toward deductibles and stop-loss limits are combined with in-network/out-of-state deductibles and stop-loss limits.*
HIGH OPTION All Areas	90% coverage of eligible medical and hospital charges (unless noted), subject to Plan Year deductibles: $300 per person with a $900 family maximum. (See Behavioral Health Services.) $100 inpatient hospital deductible per confinement. 90% coverage for eligible physician office visit charges, **including preventive care visits**, after deductible. 100% coverage for eligible preventive lab work and tests, **up to $200 per Plan Year,** plus an additional amount for specified services with no deductible. **Three-tier copayment program for covered prescription drugs.** Stop-loss limits the deductibles and coinsurance to $1500 of eligible out-of-pocket expenses per person, or $2500 per family per Plan Year; thereafter, benefits are payable at 100% of eligible charges, unless noted. *Ineligible charges, copayments, and MCP penalties do not apply to deductibles or stop-loss limits. Lifetime benefit maximums are combined with PPO Option.*

continued next page

Options /Service Area	**Description of Key Features (cont'd)**
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	100% coverage for eligible medical and hospital charges from network providers (unless noted), subject to copayments or coinsurance as indicated. (See Behavioral Health Services.) 100% coverage for eligible physician office visit charges, after copayment. Preventive care covered as indicated. Three-tier copayment program for covered prescription drugs. No deductibles.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	100% coverage for eligible medical and hospital charges from network providers (unless noted), subject to copayments or coinsurance as indicated. (See Behavioral Health Services.) 100% coverage for eligible physician office visit charges, after copayment. Preventive care covered as indicated. Two-tier copayment program for covered prescription drugs. No deductibles.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	100% coverage for eligible medical and hospital charges from network providers (unless noted), subject to copayments or coinsurance as indicated. (See Behavioral Health Services.) 100% coverage for eligible physician office visit charges, after copayment. Preventive care covered as indicated. Two-tier copayment program for covered prescription drugs. No deductibles.

Options /Service Area	**Providers of Service**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia **IN-NETWORK BENEFITS** Out-of-State	You and each covered dependent must use physicians from the PPO network to receive the higher level of in-network benefits. For inpatient care, you must use one of the listed hospitals with which the PPO has a contract and at which your physician has admitting privileges. Prescription drugs may be obtained at any participating pharmacy. Referrals for specialty care are not required. Coverage is available for out-of-state providers in selected areas at in-network benefit coverage levels. Provider directories for the Georgia network are available online or for viewing in your personnel/payroll office. Provider directories for the national network are available online or by phone request. See page 34.
OUT-OF-NETWORK BENEFITS All Areas	Any lawfully operated hospital, licensed physician, licensed pharmacy or other qualified provider of medical services. Balance billing may apply.
HIGH OPTION All Areas	Any lawfully operated hospital, licensed physician, licensed pharmacy or other qualified provider of medical services. Coverage for out-of-state and non-participating providers is subject to balance billing. Referrals for specialty care are not required.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	You and each of your eligible dependents must choose a participating primary-care physician from the appropriate Aetna U.S. Healthcare network. For inpatient care, you will be referred to a hospital with which the HMO has contracted for care of its members, and at which your physician has admitting privileges. Prescription drugs are available from any Aetna U.S. Healthcare participating pharmacy. Prescriptions for 90-day supplies of maintenance medications are covered through a mail order program **or at participating pharmacies**. Members may self-refer to any participating provider for covered OB/GYN, dermatology, vision care and mental health/substance abuse care.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	You and each covered dependent must select a primary-care physician (PCP) from the enclosed directory. For inpatient care, you will be referred to one of the listed hospitals with which ***HMO Georgia*** (BlueChoice HMO) has a contract, and at which your physician has admitting privileges. Prescription drugs may be obtained at any participating BlueChoice pharmacy. Members may self-refer to any participating provider for covered OB/GYN, dermatology, opthamology, chiropractic, and mental health/substance abuse care.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	You can choose your physician from either a Kaiser Permanente medical center or from a group of Affiliated Community Physicians practicing in their own office. If you select an Affiliated Community Physician, that doctor or another Affiliated Community Physician who practices in the same office will provide your care. If you decide to receive care from a doctor not practicing in your doctor's office, you will need to contact Kaiser Permanente before receiving treatment to select that individual as your new physician and to have coverage. Your physician choice will determine where you will receive specialty and inpatient care. Prescription drugs are available from Kaiser Permanente medical center pharmacies and participating community pharmacies. Members may self-refer to any participating provider for covered OB/GYN, dermatology, and mental health/substance abuse, vision, and chiropractic care.

Options /Service Area	Coverage Outside Service Area
STANDARD PPO **PPO CHOICE** All Areas	**Emergency or Acute Care** Non-participating provider charges for emergency or acute care are covered at the 90% in-network benefit level, subject to the in-network /Georgia deductible and to balance billing. $60 copayment for emergency room treatment of life-threatening emergencies or acute illness/accidental injury. Emergency room copayment is waived if admitted or reduced to $40 if referred by NurseCall 24. Inpatient admissions and specified outpatient procedures require pre-certification through the MCP. Services that may not be available through participating network PPO providers must be pre-authorized and approved by the Plan to receive in-network benefit coverage levels. NurseCall 24 information service is available toll-free 24 hours per day, seven days per week. **Preventive or Planned Care** Out-of-network benefit coverage levels apply for services received through a non-participating provider. Preventive care is not covered out-of-network. Charges from providers who are not in the PPO are subject to balance billing. Inpatient admissions and specified outpatient procedures require pre-certification through the MCP. NurseCall 24 information service is available toll-free 24 hours per day, seven days per week.
HIGH OPTION All Areas	Location does not affect benefit levels or deductibles. $60 copayment for emergency room treatment of life-threatening emergencies or acute illness/accidental injury. Emergency room copayment is waived if admitted or reduced to $40 if referred by NurseCall 24. Charges from physicians who are not in the PPP (see Definitions) are subject to balance billing. Charges from non-contracted hospitals are subject to balance billing. Inpatient admissions and specified outpatient procedures require pre-certification through the MCP. NurseCall 24 information service is available toll-free 24 hours per day, seven days per week.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	$50 copayment for emergency room treatment of acute illness or accidental injury. The copayment is waived if the patient is admitted. Members should seek the nearest medical facility for emergency care.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	$50 copayment for hospital emergency room treatment of acute illness or accidental injury. Copayment is waived if admitted. For urgent care, BlueChoice offers facilities across the U.S. through HMO U.S.A. Members access local networks by calling a national hotline number. A 24 hour per day, 7 days per week toll-free nurse help-line is available. Members with eligible dependents residing anywhere in the continental U.S. where Blue Cross Blue Shield plans have operating HMOs may enroll their dependents in the HMO Guest Membership Program.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	$50 copayment for hospital emergency room treatment of acute illness or accidental injury, unless patient is admitted. $25 copayment for outpatient follow-up or continuing medical care when outside of any other Kaiser Foundation Health Plan service area by more than 100 miles. Up to $500 per calendar year for follow-up care associated with emergency room treatment is covered for members outside the service area. Kaiser Permanente has facilities across the United States (see HMO Physician Directory.)

Options / Service Area	**Physician Visits**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Office visits for both primary and specialty care are covered at 100% after a per visit copayment of $20 is paid. Office visits are not subject to a general deductible. (Also see office visit coverage under Preventive (Wellness) Care.) Inpatient physician visits are covered at 90% of network rate after meeting the general deductible. Certain diagnostic procedures require precertification from the Medical Certification Program (MCP) or reimbursement is reduced. Amounts over the negotiated network rate are not subject to balance billing by the provider.
IN-NETWORK BENEFITS Out-of-State	Same as above except that **inpatient physician visits are covered at 80% of network rate after meeting general deductible.**
OUT-OF-NETWORK BENEFITS All Areas	Office visits and inpatient physician visits are covered at 60% of the OON rate (see Definitions) after the out-of-network deductible is met. Certain diagnostic procedures require pre-certification from the MCP or reimbursement is reduced. Amounts over the OON rate are subject to balance billing by the provider.
HIGH OPTION All Areas	Office visits and inpatient physician visits are covered at 90% of the H/O rate (see Definitions) after the general deductible is met. (Also see office visit coverage under Preventive (Wellness) Care.) Second opinions are paid at 100%, if recommended by the MCP. Certain diagnostic procedures require precertification through MCP or reimbursement is reduced.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Office visits for primary care are covered in full after a $10 copayment and after a **$20 copayment for specialty care**. Inpatient physician visits are covered in full. Visits for diagnosis and limited treatment of infertility are covered after a **$20 copayment**. Members must contact an infertility case manager before covered care is rendered. Outpatient lab and x-ray outside the physician's office covered with **$20 copayment**. Chiropractic care is covered with a **$20 copayment** up to 20 visits per year with a referral from your primary care physician to a participating provider. No referral is necessary for visits to network dermatologists, OB/GYNs, opthamologists, optometrists and mental health providers.
BLUECHOICE **BLUECHOICE CCO** Atlanta Macon Augusta Savannah	Office visits for primary care are covered in full after a $10 copayment and after a $15 copayment for specialty care. Network chiropractors may be visited up to 20 times per policy year subject to a $15 office visit copayment. No referral is necessary for visits to network dermatologists, OB/GYNs, opthamologists, mental health providers and chiropractors. Inpatient physician visits are covered at 100%.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Office visits for primary care are covered in full after a $10 copayment and **after a $15 copayment for specialty care**. Visits to our "After Hours" locations are covered in full after a $20 copayment. Inpatient physician visits are covered in full. Visits for infertility services (diagnosis and treatment) are covered in full after a **$15 copayment** (see Exclusions). Outpatient lab and x-ray (except infertility services) are covered at 100%; infertility lab and x-ray are covered in full after a **$15 copayment**. $5 copayment per visit for allergy injections. $50 copayment for every six-month supply of maintenance serum for allergy care. Up to 30 chiropractic visits per calendar year are covered at participating chiropractic offices after a $10 copayment; the initial visit does not require a referral, subsequent visits are covered only when medically necessary. You may self-refer to any participating provider for covered OB/GYN, dermatology, opthamology, and mental health/substance abuse care.

Options /Service Area	**Hospital Services**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 90% of network rate subject to general deductible. Balance billing does not apply. In-network hospitals pre-certify inpatient admissions. General deductible and coinsurance can be applied to the stop-loss limit. Mental health and substance abuse benefits are limited; see Behavioral Health Care.
IN-NETWORK BENEFITS Out-of-State	Same as above with the following exceptions: **Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 80% of the network rate subject to general deductible. Members are responsible for pre-certifying hospital stays at in-network/out-of-state facilities.**
OUT-OF-NETWORK BENEFITS All Areas	Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 60% of the OON rate and are subject to the general deductible. Balance billing may apply. MCP pre-certification is required or reimbursement is reduced. General deductible and coinsurance can be applied to the stop-loss limit. Mental health and substance abuse benefits are limited; see Behavioral Health Care.
HIGH OPTION All Areas	Semi-private, ICU, CCU, and miscellaneous hospital charges are covered at 90% of the H/O rate after a $100 hospital deductible is met. Coverage for non-contracted hospitals is subject to balance billing. Hospital deductible is per admission. (Must call MCP or reimbursement is reduced.) Physician charges while an inpatient are subject to the general deductible. Deductibles and coinsurance can be applied to the stop-loss limit. Mental health and substance abuse benefits are limited; see Behavioral Health Care.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Semi-private (private room if medically necessary) upon referral by primary care physician or in an emergency, ICU, CCU, and miscellaneous hospital charges covered in full as approved by the HMO. For complex medical problems where care is not available in the area, the HMO arranges care through the National Medical Excellence Program. Mental health benefits and substance abuse treatment is limited; see Behavioral Health Care.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	All hospital services are covered at 100% when authorized by your primary care physician. Mental health and substance abuse benefits have limitations; see Behavioral Health Care.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Semi-private (private room if medically necessary), ICU, CCU, and miscellaneous hospital charges covered in full as approved by the Medical Group Chief of Quality Resource Management or Chief of Network services, or their designee. Mental health benefits and substance abuse treatment are limited; see Behavioral Health Care.

Options / Service Area	**Surgical Care**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	90% of the discounted network rate for professional services and associated institutional charges. 10% coinsurance can be applied to the stop-loss limit. Certain outpatient surgical procedures require precertification from the MCP or reimbursement is reduced. Payment for surgical care is subject to the general deductible. Amounts over the discounted network rate are not subject to balance billing by the provider.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **80% of the discounted network rate for professional services and associated institutional charges. 20% coinsurance can be applied to the stop-loss limit.** Amounts over the discounted network rate are not subject to balance billing by the provider.
OUT-OF-NETWORK BENEFITS All Areas	60% of the OON rate for professional services and associated institutional charges. 40% coinsurance can be applied to the stop-loss limit. Certain outpatient surgical procedures require precertification from the MCP or reimbursement is reduced. Payment for surgical care is subject to the out-of-network deductible. Amounts over the OON rate are subject to balance billing by the provider.
HIGH OPTION All Areas	90% of the H/O rate for professional services and for associated institutional charges. 10% coinsurance can be applied to the stop-loss limit. Certain outpatient surgical procedures require precertification through MCP or reimbursement is reduced. Payment for surgical care is subject to the general deductible. Amounts over the allowed amount are subject to balance billing by the provider, unless you are using a participating provider.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Inpatient surgery and outpatient surgery are covered in full with a referral from an Aetna U.S. Healthcare participating primary care physician, or in an emergency.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	Both inpatient and outpatient surgery are covered at 100% when authorized by your primary care physician.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Inpatient surgery covered in full, outpatient surgery covered in full when authorized by the Medical Group Chief of Quality Resource Management or Chief of Network services, or their designee. Outpatient surgery performed by primary care physician covered in full after a $10 copayment and **after a $15 copayment if performed by specialist.**

Options /Service Area	**Emergency Services**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	$60 copayment per visit to emergency room; waived if admitted to hospital. If you are referred by the NurseCall 24 information service, the copayment is reduced to $40; see Wellness Programs. After the emergency room copayment and general deductible are met, coverage is 90% of network rate for emergency or acute treatment of illness or injury and for associated expenses. Copayment does not count toward general deductible or stop-loss. If surgery is performed without being admitted, institutional charges are payable at 90% of network rate, subject to general deductible. If emergency admission occurs, the MCP must be called within one business day unless at an in-network hospital; general deductible applies. For urgent care in a participating center, coverage is 100% of network rate after a per visit copayment of $35.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **Charges for covered emergency services are applied to in-network/Georgia deductibles and stop-loss limits. Members must contact MCP within one business day if admitted.**
OUT-OF-NETWORK BENEFITS All Areas	$60 copayment per visit to emergency room; waived if admitted to hospital. If you are referred by the NurseCall 24 information service, the copayment is reduced to $40; see Wellness Programs. After the emergency room copayment and in-network/Georgia deductible are met, coverage is 90% of network rate for emergency or acute treatment, subject to balance billing. Copayment does not count toward in-network/Georgia deductible or stop-loss. If surgery for emergency or acute condition is performed without being admitted, institutional charges are payable at 90% of network rate, subject to in-network/Georgia deductible and to balance billing. If emergency admission occurs out-of-network, the MCP must be called within one business day; in-network/Georgia deductible applies. Note: Charges for covered emergency services are applied to in-network/Georgia deductibles and stop-loss limits.
HIGH OPTION All Areas	$60 copayment per visit to emergency room; waived if admitted to hospital. If you are referred by the NurseCall 24 information service, the copayment is reduced to $40; see Wellness Programs. After the emergency room copayment and general deductible are met, coverage is 90% of H/O rate for emergency or acute treatment of illness or injury and for associated expenses. If out-patient surgery is performed, institutional charges are payable at 90% of H/O rate, subject to hospital deductible. Copayment does not count toward general deductible or stop-loss. If emergency admission occurs, the MCP must be called within one business day unless at a hospital contracting directly with the SHBP; hospital deductible applies. Charges from non-participating providers are subject to balance billing.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	$50 copayment per visit (illness or injury) for emergency room services. Covered when there is a life-threatening emergency or when authorized by your primary care physician. If the emergency results in a hospital admission, the emergency room copayment is waived.
BLUECHOICE **BLUECHOICE CCO** Atlanta Macon Augusta Savannah	$50 copayment for outpatient emergency room services when there is a life-threatening emergency, or when authorized by your primary care physician or the on-call nurse. Members may obtain treatment at any licensed medical facility. Copayments are waived if admitted.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	$50 copayment for emergency room visits or when authorized by a Kaiser Permanente physician. Copayment is waived if admitted. $50 copayment for emergency ambulance transportation. $20 copayment at Kaiser Permanente medical center after regular office hours.

Options / Service Area	Prescription Drugs
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** (Express Scripts Pharmacy Network) **IN-NETWORK BENEFITS** Out-of-State	**$10 copayment for generic drugs; $20 copayment for preferred brand name drugs; 20% coinsurance for non-preferred brand name drugs, with a $35 minimum and $75 maximum copayment. When a member chooses a preferred brand name or non-preferred brand name drug over its generic equivalent, the member will be responsible to "pay-the-difference" between the two in addition to the generic copayment. If the treating physician mandates the preferred brand or non-preferred brand over the generic, the "pay-the-difference" feature will not apply. The member will be responsible for paying the preferred brand or non-preferred brand copayment amount. If the drug's usual and customary cost is less than the copayment, the member pays the drug's usual and customary cost. Copayments are based upon supplies of up to 30 days; some drugs are limited to a standard other than 30-day supplies. You may obtain up to a 90-day supply for your initial prescription and for each refill (if written for 90 days) with one copayment per 30-day supply for drugs listed as maintenance drugs under the plan. Deductible does not apply to prescription drug benefits. Express Scripts has a national network of participating pharmacies. You may visit www.dch.state.ga.us for locations in Georgia or call 1-877-650-9342.**
OUT-OF-NETWORK BENEFITS (Pharmacy Not in Express Scripts Network)	**Member must pay charges at point of sale and submit a paper claim with a pharmacy receipt. Members will be reimbursed at the pharmacy network rate less the required copayment for those drugs covered by the Plan. Limitations and restrictions indicated above also apply to covered drugs purchased out-of-network. Charges are subject to balance billing.**
HIGH OPTION All Areas	**Same as Standard PPO option. Deductible does not apply to prescription drug benefit.**
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	For a 30-day supply of prescription drugs: $10 copayment per generic formulary prescription or refill; $15 copayment for name brand formulary; $30 copayment for non-formulary. Oral contraceptives are covered. Members must use a participating Aetna U.S. Healthcare pharmacy. Prescription maintenance drugs are available up to a 90-day supply for a double copayment through a mail order drug program **or at participating pharmacies.**
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	$10 copayment for up to a 30-day supply of generic prescribed drugs and a $20 copayment for up to a 30-day supply of prescribed name brand drugs listed in the BlueChoice Health Care Plan drug formulary, filled at any BlueChoice participating pharmacy. All prescriptions must be written by an authorized network provider. Check your provider directory for a complete listing of participating pharmacies.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	$10 copayment for up to the lesser of a 30 days' supply or the standard prescription amount of prescribed covered drugs listed in the Kaiser Permanente Drug Formulary, if obtained at a Kaiser Permanente medical center pharmacy; $16 copayment if obtained at a participating community pharmacy.

Options /Service Area	**Preventive (Wellness) Care**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Physician fees for office visits covered at 100% of network rate after a per visit copayment of $20. Covered lab work and tests associated with preventive care visits are paid at 100% of the negotiated network rate with no copayment, up to a maximum of $500 per year per person (at network rate). The $500 annual maximum for associated lab work and tests applies to such services as: mammograms, PSAs, EKGs, and pap smears. Annual maximum is combined total with in-network/out-of-state benefit. Coverage is based on age schedules and medical history; age schedules are available online at *www.healthygeorgia.com* or by calling member services. Routine preventive care is not subject to the general deductible.
IN-NETWORK BENEFITS Out-of-State	Same as above.
OUT-OF-NETWORK BENEFITS All Areas	Not covered. Charges do not apply to general deductible or annual out-of-pocket (stop-loss) limits.
HIGH OPTION All Areas	Physician fees for office visit **are covered at 90% of H/O rate after meeting the general deductible. Covered lab work and tests associated with preventive care visits are paid at 100% of H/O rate with no deductible, up to a maximum of $200 per year per person (at H/O rate). The $200 annual maximum for associated lab work and tests applies to such services as: PSAs, EKGs, and pap smears. Coverage is based on age schedules and medical history; age schedules are available online at** *www.healthygeorgia.com* **or by calling member services.** Up to an additional **$125** for screening mammogram. Balance billing may apply unless using a participating provider.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Routine check-ups, well-baby/well-child care, immunizations, lab tests, including screenings for breast and colorectal cancer, routine allergy shots, PAP smears, prostate screening, and GYN exams are covered in full after copayment. Primary-care copayments are $10 per visit and specialty-care copayments are **$20** per visit. Program available to identify high-risk pregnancies and promote safe births of healthy babies. First OB visit - **$20** copayment, then covered at 100% for prenatal visits.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	Well-baby/well-child care, immunizations, routine check-ups, physical examinations, GYN exams, and mammograms are covered in full after an office visit copayment. Primary-care copayments are $10 per visit and specialty-care copayments are $15 per visit. Depending on age, some routine care is not covered annually.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Routine check-ups and preventive health screenings (including pap smears and prostrate screening exams for adults) are covered in full after a $10 copayment for primary care and after **a $15 copayment for specialty care**. Mammograms are covered at 100%. All prenatal visits and the first postnatal visit are covered at 100%. Well-baby/well-child care and immunizations are covered at 100% up to age 24 months and with a $10 copayment thereafter.

Options /Service Area	**Wellness Programs**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Outpatient self-management training and educational services covered at 100% of the discounted network rate when participating in an approved disease state management program for diabetes, oncology, congestive heart failure, or asthma. Toll-free NurseCall 24 information service line available 24 hours per day, 7 days per week to answer any health-related questions and to assist Plan participants in determining the most appropriate level of care when medical attention is requested, including emergency room referrals. A self-care guide, health brochures, and telephone access to health-library recordings are available by request from NurseCall 24. Other publications covering a full range of health topics are mailed to the member. See Preventive (Wellness) Care for coverage of office visits and associated lab work and tests. Visit the MRN/Georgia 1st Web site at *www.healthygeorgia.com* for wellness information.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **Outpatient self-management training and educational services covered at 80% of the discounted network rate when participating in an approved disease state management program for diabetes, oncology, congestive heart failure, or asthma.**
OUT-OF-NETWORK BENEFITS All Areas	Toll-free NurseCall 24 information service line and educational materials available as discussed above. Other publications covering a full range of health topics are mailed to the member. No coverage for preventive care office visits and associated lab work and tests.
HIGH OPTION All Areas	Outpatient self-management training and educational services covered at 100% of the discounted network rate when participating in an approved disease state management program for diabetes, oncology, congestive heart failure, or asthma. Toll-free NurseCall 24 information service line and educational materials available as discussed above. Other publications covering a full range of health topics are mailed to the member.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Aetna U.S. Healthcare offers a number of wellness programs: a nutritional program; expectant mother and father programs; and a health education program with brochures on a full range of health related topics. A **Web site** offers information on wellness programs as well as an interactive feature with health and fitness articles. **A 24-hour toll-free Informed HealthLine** links members to registered nurses who can provide information and support on a variety of health issues. For more information on additional programs, call Aetna U.S. Healthcare.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	A toll-free nurse-help line available 24 hours per day, 7 days per week to answer any health-related questions and to assist Plan participants in determining the most appropriate level of care when medical attention is requested, including emergency room referrals. Telephone access to an extensive library of health related recordings and educational publications mailed to your home are also available. BlueChoice Healthcare Plan also sponsors a number of wellness programs covering nutrition, weight management, health behavior/lifestyle identification, and injury prevention. Member education newsletters are provided quarterly.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Kaiser Permanente offers a variety of health education programs, publications, and self-care tools. They include over 200 health education classes; a toll-free line members can call to get recorded messages on health topics; a self-care handbook, which includes guidelines on recognizing and treating common health problems; a free confidential interactive Web site offering services, information, and advice from health care professionals 24 hours a day; and a quarterly member magazine containing information on preventive care, medical centers, membership, and health education classes.

Options / Service Area	**Behavioral Health Care**
STANDARD PPO **PPO CHOICE** All Areas **IN-NETWORK BENEFITS (BHS network providers)**	**With BHS Referral** Inpatient hospital services for mental health and substance abuse are covered at 90% for up to a combined total of 60 days per person, per Plan Year; associated professional fees are covered at 80% for up to 60 visits. Partial/Day hospitalization is covered at 90% for up to 30 days/visits per Plan Year. Out-patient professional services for mental health and substance abuse are covered at 80% for up to 50 visits per Plan Year. Visit limitation includes up to three brief situational counseling sessions covered at 100% without deductible. Substance abuse treatment is limited to three episodes per lifetime. All eligible charges are subject to deductibles ($300 general deductible and $100 per confinement hospital deductible) and to a separate stop-loss limit of $2500 per person, per Plan Year. See the 11/1/95 Plan booklet for full details on coverage provisions and exclusions. BHS has a national network of providers. BHS providers are not part of the PPO network. **Without BHS Referral** Inpatient hospital services for mental health and substance abuse are covered at 60% of the average network per diem rate when certified as medically necessary care for up to a combined total of 60 days per Plan Year; associated professional fees are covered at 50% of the network rate for up to 25 visits per Plan Year. Outpatient professional (MD/PhD) services for mental health and substance abuse are covered at 50% of the network rate for up to 25 visits per Plan Year. Substance abuse treatment with BHS certification is limited to three episodes per lifetime. All eligible charges are subject to deductibles and do not accumulate toward any stop-loss limit. Balance billing may apply. See the 11/1/95 Plan booklet for full details on coverage provisions and exclusions.
OUT-OF-NETWORK BENEFITS	Not Applicable.
HIGH OPTION All Areas	**With BHS Referral** Same coverage as Standard PPO In-Network Benefits. **Without BHS Referral** Same coverage as Standard PPO In-Network Benefits.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Inpatient hospital and physician services are covered at 80% for 60 days per covered person in a calendar year. Outpatient services are covered at 100% for three brief situational counseling visits with a participating mental health professional in a calendar year. Outpatient professional psychiatric services are covered at 50% for no more than 20 visits in a calendar year. Substance abuse treatment is limited to three episodes per lifetime.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	Inpatient hospital and physician services are covered at 80% for 60 days per person each calendar year. Outpatient services are covered at 100% for three brief situational counseling visits with a network mental health provider in a calendar year. Outpatient physician services are covered at 100%, subject to a $25 copayment per visit for no more than twenty 50-minute visits in a calendar year. Substance abuse treatment is limited to three episodes per lifetime.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Inpatient hospital and physician services are covered at 80% for 60 days per person and 50% thereafter in a calendar year. Outpatient services are covered at 100% for three brief situational counseling visits received from a Kaiser Permanente counselor per person in a calendar year. Outpatient professional psychiatric services are covered at 50%. Substance abuse treatment is limited to three episodes per lifetime.

Options /Service Area	**Home Health Care/Skilled Nursing**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician; covered at 90% of network rate after the general deductible has been met, up to a maximum of $7,500 per person per Plan Year. Annual maximum is combined with in-network/out-of-state benefit. Home health care charges are not applied to the stop-loss limit. If the MCP recommends home care in place of hospital care, additional benefits may be approved. No coverage for skilled nursing facilities. Hospice care covered at 100% when approved by the MCP, subject to the lifetime benefit maximum approved by Medicare.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician; covered at 80% of network rate after the general deductible has been met, up to a maximum of $7,500 per person per Plan Year.**
OUT-OF-NETWORK BENEFITS All Areas	Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician; covered at 60% of OON rate after the general deductible has been met, up to a maximum of $7,500 per person per Plan Year. Annual maximum is combined with in-network benefits. Home health care charges are not applied to the stop-loss limit. If the MCP recommends home care in place of hospital care, additional benefits may be approved. No coverage for skilled nursing facilities. Hospice care covered at 60% when approved by the MCP, subject to the lifetime benefit maximum approved by Medicare.
HIGH OPTION All Areas	Two hours of home care per day by RN or LPN, if medically necessary and ordered by a physician; covered at 90% of H/O rate after the general deductible has been met, up to a maximum of $7,500 per person per Plan Year. Home health care charges are not applied to the stop-loss limit. If the MCP recommends home care in place of hospital care, services are covered at 100%. No coverage for skilled nursing facilities. Hospice care covered at 100% when approved by the MCP, subject to the lifetime benefit maximum approved by Medicare.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Home health care and skilled nursing facility care covered at 100%, including physician and nursing services, diagnostic tests, medical supplies, physical and occupational therapy, and home health aides, when authorized by your participating primary care physician and Aetna U.S. Healthcare's Home Care Department.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	RN or LPN visits covered in full for up to 120 visits per calendar year when authorized by your primary care physician. Skilled nursing facilities covered in full for 45 days (lifetime maximum), when medically necessary and authorized by a BlueChoice physician.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Part-time RN or LPN services covered in full when medically necessary. Skilled-nursing facilities covered in full for 45 days (lifetime maximum) when medically necessary. All services for home health care and skilled nursing must be approved by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee.

Options /Service Area	**Outpatient Physical Therapy**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Up to 40 visits per Plan Year covered at 90% of network rate after general deductible is met. Visit limitation is combined with in-network/out-of-state benefit and/or out-of-network benefit.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **Up to 40 visits per Plan Year covered at 80% of network rate after general deductible is met.**
OUT-OF-NETWORK BENEFITS All Areas	Up to 40 visits per Plan Year covered at 60% of OON rate after general deductible is met.
HIGH OPTION All Areas	Up to 40 visits per Plan Year covered at 90% of H/O rate after general deductible is met.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	**$20** copayment per visit for short-term treatment (60 consecutive days, per condition, per calender year).
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	$15 per visit for up to 40 visits per calendar year when authorized by your primary care physician.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	**$15** copayment per visit for short-term treatment (60 consecutive days per condition), and **$15** per visit copayment for cardiac rehabilitation (up to 12 weeks or 36 visits) when authorized by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee.

Options / Service Area	**Durable Medical Equipment**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Covered at 90% of network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment from a participating provider that is medically necessary and approved by a participating physician and is approved by the SHBP. Examples of durable medical equipment include canes, crutches, wheelchairs, etc. (See Definitions.) Balance billing does not apply when using a participating provider.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **Covered at 80% of network rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment from a participating provider that is medically necessary and approved by a participating physician and is approved by the SHBP.**
OUT-OF-NETWORK BENEFITS All Areas	Covered at 60% of OON rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment that is medically necessary and is approved by the SHBP. Balance billing may apply.
HIGH OPTION All Areas	Covered at 90% of H/O rate after the general deductible is met, for rental or purchase of certain basic durable medical equipment that is medically necessary and approved by a participating physician and the SHBP. Balance billing may apply.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Covered in full for certain durable medical equipment that is medically necessary and approved by your Aetna U.S. Healthcare participating primary care physician.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	100% coverage when medically necessary and authorized by your primary care physician.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Covered in full for equipment in accordance with Medicare guidelines and that is medically necessary and approved by the Medical Group Chief of Quality Resource Management or Chief of Network Services, or their designee.

Options /Service Area	**Dental Care**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia	Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified surgical procedures. Payment for covered dental services is 90% of network rate after the general deductible is met. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of temporomandibular joint dysfunction (TMJ) is $1,100. Lifetime limit is combined total for PPO and High Option. Hospital charges for these procedures are covered as are other hospital costs; see Hospital Services.
IN-NETWORK BENEFITS Out-of-State	Same as above except: **Payment for covered dental services is 80% of network rate after the general deductible is met.**
OUT-OF-NETWORK BENEFITS All Areas	Benefits are provided for dental work done in connection with the prompt repair of damage to natural tissue or natural teeth and for specified surgical procedures. Payment for covered dental services is 60% of OON rate after the general deductible is met. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is $1,100. Lifetime limit is combined total for PPO and High Option. Hospital charges for these procedures are covered as are other hospital costs; see Hospital Services.
HIGH OPTION All Areas	Benefits are provided for dental work done only in connection with the prompt repair of damage to natural tissue or natural teeth and for specified surgical procedures. After meeting the general deductible, payment for covered dental services is 90% of H/O rate. Extraction of impacted teeth is not covered. Lifetime benefit limit for treatment of TMJ is $1,100. Lifetime limit is combined total for PPO and High Option. Hospital charges for these procedures are covered as are other hospital costs; see Hospital Services.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Dental procedures for surgery or treatment of the teeth and gums for tumors and cysts, fractures of the jaw, and repair of accidental injury to sound natural teeth is covered at 100%. Extraction of bony impacted wisdom teeth is covered. TMJ is covered with primary care physician referral to specialist for the surgical or non-surgical treatment of TMJ, including oral appliances. Periodontal surgery is not covered.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	100% coverage for oral surgery and dental services for accidental injury to sound teeth. Extraction of impacted wisdom teeth and TMJ are included as covered medical services. Periodontal surgery is not covered.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Dental care for accidental injury to sound natural teeth is covered at 80% of charges for dental surgery and appliances for mouth, jaw, and tooth restoration performed within 365 days after the injury. Non-surgical dental treatment and appliances for TMJ are covered at 50%. Extraction of impacted wisdom teeth is not covered. Periodontal surgery is not covered.

Options /Service Area	**Maximum Benefits**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia **IN-NETWORK BENEFITS** Out-of-State	$2,000,000 per person for lifetime. When an employee or an eligible dependent enrolls (except for a dependent child being enrolled at birth), benefits payable for treatment of a pre-existing condition are limited to $1,000 until the patient has been free of treatment for six months or has been insured under the SHBP for a year; waiting period may be reduced based on federal legislation. Separate lifetime benefit maximums include the following: $1,100 for the treatment of TMJ; three episodes of substance abuse treatment; $500,000 combined limit for organ and tissue transplants; and $500,000 for home hyperalimentation. Lifetime benefit maximums are combined with High Option.
OUT-OF-NETWORK BENEFITS All Areas	Benefits paid to out-of-network providers are applied toward in-network maximums described above. There are no separate out-of-network limits for pre-existing conditions or lifetime benefit maximums.
HIGH OPTION All Areas	Same as Standard PPO. Lifetime benefit maximums are combined with PPO maximums.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	No maximum.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	No maximum.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	No maximum.

Options /Service Area	**Major Exclusions**
STANDARD PPO **PPO CHOICE** **IN-NETWORK BENEFITS** Georgia **IN-NETWORK BENEFITS** Out-of-State	Custodial care; dental services (except as noted); routine vision care (see Vision Screenings); in vitro fertilization; reversal of sterilization procedures; infertility drugs; non-prescription items; cosmetic surgery. For limitations regarding pre-existing conditions, see Maximum Benefits. This is a summary of exclusions and not a complete list.
OUT-OF-NETWORK BENEFITS All Areas	Preventive care; dental services (except as noted); routine vision care (see Vision Screenings); well-baby and well-child care; custodial care; in vitro fertilization; reversal of sterilization procedures; infertility drugs; non-prescription items; cosmetic surgery. For limitations regarding pre-existing conditions, see Maximum Benefits. This is a summary of exclusions and not a complete list.
HIGH OPTION All Areas	Custodial care; dental services (except as noted); routine vision care (see Vision Screenings); in vitro fertilization; reversal of sterilization procedures; infertility drugs; non-prescription items; cosmetic surgery. For limitations regarding pre-existing conditions, see Maximum Benefits. This is a summary of exclusions and not a complete list.
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Services not provided or authorized or referred by your Aetna U.S. Healthcare primary care physician (except in an emergency); reversal of sterilization procedures; periodontal surgery and non-prescription medications. Advanced reproductive techniques, including in vitro fertilization (IVF), gamete interfallopian transfer (GIFT), zygote interfallopian transfer (ZIFT), embryo transfers and related procedures and injectable medications for infertility are not covered. This is a summary of exclusions and not a complete list.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	Services not provided or authorized by your primary care physician (except life-threatening emergencies), routine vision check-ups, dental care (except the removal of impacted wisdom teeth and the treatment of TMJ), periodontal surgery, in vitro fertilization, long-term physical therapy, learning disabilities, reversal of voluntary sterilization, custodial care, non-prescription items. This is a summary of exclusions and not a complete list.
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	Services not provided or authorized by a Kaiser Permanente physician except in emergencies; advanced reproductive techniques, such as IVF; long-term physical therapy; custodial care; periodontal surgery; extraction of impacted wisdom teeth; non-prescription items; prescription drugs not listed in the Kaiser Permanente Drug Formulary (an exception process is available); disposable supplies. This is a summary of exclusions and not a complete list.

Options / Service Area	**Vision Screenings for Corrective Lenses and Eye Wear**
STANDARD PPO **PPO CHOICE** All Areas **IN-NETWORK BENEFITS** (Participating Vision Providers)	Members are eligible for a value-added vision discount program at participating LensCafters stores in Georgia or independent BlueChoice vision optometrists. This is not a vision benefit but instead a discount program where you can save on eye exams and a broad selection of eye wear. Discounts at LensCafters include: three-tiered selection of eyeglasses through preset, discounted package prices; 30% off the regular retail price of any non-BlueChoice Vision package eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices by independent doctors of optometry located at LensCrafters; 25% off the regular retail price on non-prescription sunglasses. Discounts at independent BlueChoice vision optometrists: 30% off the regular retail price of any eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices; 25% off the regular retail price on non-prescription sunglasses. For a list of providers or to learn more about the program, please call 800-377-6436 or visit the BlueCross BlueShield Web site at *www.bcbsga.com.*
OUT-OF-NETWORK BENEFITS	Not applicable
HIGH OPTION All Areas	Same as Standard PPO Option
AETNA U.S. HEALTHCARE **AETNA U.S. HEALTHCARE CCO** Atlanta	Vision screening exams at participating specialists, ophthalmologists, or optometrists are covered in full after $20 copayment. Aetna also offers a discount program at optical centers nationwide. Please call 800-793-8616 to access the automated locator or to select DocFind on the Aetna U.S. Healthcare Web site at www.aetnaushc.com. You may be eligible for a $70 reimbursement for prescription eye wear, either contact lenses or frames and lenses, once every 24 months. Discounts effective January 1, 2001, through December 31, 2001. The discount program described is a discount-only program, which may be in addition to any plan benefits.
BLUECHOICE **BLUECHOICE CCO** Atlanta Augusta Macon Savannah	Members are eligible for a value-added vision discount program at participating LensCafters stores in Georgia or independent BlueChoice vision optometrists. This is not a vision benefit but instead a discount program where you can save on eye exams and a broad selection of eye wear. Discounts at LensCafters include: three-tiered selection of eyeglasses through preset, discounted package prices; 30% off the regular retail price of any non-BlueChoice Vision package eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices by independent doctors of optometry located at LensCrafters; 25% off the regular retail price on non-prescription sunglasses. Discounts at independent BlueChoice vision optometrists: 30% off the regular retail price of any eyeglasses; contact lenses at low fixed prices; eye exams at low fixed prices; 25% off the regular retail price on non-prescription sunglasses. For a list of providers or to learn more about the program, please call 800-377-6436 or visit the BlueCross BlueShield Web site at *www.bcbsga.com.*
KAISER PERMANENTE **KAISER PERMANENTE CCO** Atlanta	$15 copayment per visit for eye exams for corrective lenses (and screenings for eye diseases) from participating providers designated by Kaiser Permanente. Additionally, you receive a 25% discount off of eyeglasses, a 15% discount off of regular contact lenses, and a 5% discount off of disposable contact lenses when purchased from participating providers designated by Kaiser Permanente.

Service Areas for State Health Benefit Plan Options

Standard PPO and PPO Choice Options

Effective July 1, 2001, the PPO Option will have a national network available. All members will be eligible for PPO Option coverage from a PPO provider participating in the national Beech Street network outside Georgia. Please consider the following points if you require care while traveling or if you or a dependent lives outside the state or you wish to receive care from a national PPO provider outside of Georgia:

- Benefit coverage under the PPO Options generally will be at one of three levels depending on where you receive care. Coverage will be at the 90% level for in-network PPO services received in-state and in the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama; 80% for in-network PPO services received out-of-state; and 60% for out-of-network services received in any area.
- Members are responsible for precertifying inpatient stays and specified out-patient tests and procedures, whether or not the provider participates in the national network.
- **The national PPO network used by the Health Plan does not include any providers in Georgia.** Providers throughout Georgia participate in the PPO through the MRN/Georgia 1st joint venture. A 90% level of benefit coverage is available for these providers.
- If you require emergency care or acute care (see Definitions), the Plan will pay the higher in-network level of benefits coverage (90%), regardless of where you receive care or treatment. However, if you use a participating PPO provider, you are not subject to balance billing and could save money. Additionally, if you use a participating provider you do not have to pay at the time you receive services since benefits are payable directly to the provider. If you or anyone with you is able, call NurseCall 24 at 1-800-524-7130 (24 hours per day, 7 days a week) for information on the nearest participating providers.
- If you are planning to travel outside of Georgia or you have a dependent living outside of Georgia, you may visit the Internet at www.healthygeorgia.com for the locations of participating providers in selected areas across the country. (This site includes a link to Beech Street network providers.) You may also contact member services (see inside front cover) to request a printed provider directory for the area(s) of your choice, or to receive provider information over the phone. (Note: There is no international network of participating providers in the PPO Options.)
- When possible, check to see if the provider is participating in the national PPO network or, if you are seeking services inside Georgia, see if the provider is in the MRN/Georgia 1st network. Be aware that it is possible that a participating hospital does not have participating hospital-based physicians, in which case you may be balance billed by those physicians.
- If you are a current PPO Choice Option member or you are considering PPO Choice, please note that you may only nominate providers located and licensed in Georgia - even if you live out-of-state.

High Option

The High Option is available to anyone eligible for SHBP coverage, regardless of residence or work location.

HMO Options (including Consumer Choice Options)

HMO Option service areas are comprised of approved counties. You must live or work in the HMO's approved service area to be eligible for coverage under that option. See pages 36 - 37 for residence or work location requirements.

Georgia Service Area for Standard PPO and PPO Choice Options

Standard PPO and PPO Choice Options

Effective July 1,2001, the PPO will no longer be restricted to members living or working in selected zip code areas. All members eligible for SHBP coverage may enroll into the Standard PPO or PPO Choice Option.

However, the Georgia service area used to determine the in-network/Georgia level of benefit coverage will include zip codes for all of Georgia, and in the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. If you receive services from a provider that is not located in one of the zip codes listed below, then you would not be able to receive the in-network/Georgia level of benefits coverage, unless you required emergency services. Also remember that you must use an MRN/Georgia 1st provider located in one of the listed zip codes in order to receive the 90% level of benefit coverage.

Georgia:	Alabama:	Tennessee:	
All Counties	*Russell County*	*Bradley County*	*Hamilton County*
All Zip Codes	36067 36069 36867 36869	37311 37312 37320 37323	30720 31901 37311 37315 37321 37327 37331 37341 37343 37363 37377 37379 37380 37401 37402 37403 37404 37405 37406 37407 37410 37411 37412 37415 37416 37421 37499 37620

Residence/Work Location Requirements By Service Area

HMO option service areas are comprised of approved counties.

You must live or work in the HMO's approved service area to be eligible for coverage under that option.

Atlanta Service Area:

Residence/ Work County	Aetna U.S. Healthcare	Blue Choice	Kaiser Permanente
Barrow	Yes	Yes	Yes
Bartow	Yes	Yes	Yes
Butts	Yes	Yes	Yes
Carroll	Not Available	Closed to new members	Not Available
Cherokee	Yes	Yes	Yes
Clarke	Yes	Yes	Not Available
Clayton	Yes	Yes	Yes
Cobb	Yes	Yes	Yes
Coweta	Yes	Yes	Yes
Dawson	Not Available	Yes	Not Available
DeKalb	Yes	Yes	Yes
Douglas	Yes	Yes	Yes
Fayette	Yes	Yes	Yes
Forsyth	Yes	Yes	Yes
Fulton	Yes	Yes	Yes
Gwinnett	Yes	Yes	Yes
Hall	Yes	Yes	Closed to new members
Henry	Yes	Yes	Yes
Jackson	Yes	Yes	Not Available
Lumpkin	Not Available	Yes	Not Available
Madison	Not Available	Yes	Not Available
Newton	Yes	Yes	Yes
Oconee	Closed to new members	Yes	Not Available
Oglethorpe	Not Available	Closed to new members	Not Available
Paulding	Yes	Yes	Yes
Pickens	Yes	Not Available	Not Available
Rockdale	Yes	Yes	Yes
Spalding	Yes	Yes	Yes
Walton	Yes	Yes	Yes

HMO option service areas are comprised of approved counties.

You must live or work in the HMO's approved service area to be eligible for coverage under that option.

Augusta Service Area:

Residence/ Work County	Aetna U.S. Healthcare	Blue Choice	Kaiser Permanente
Burke	NOT AVAILABLE	Yes	NOT AVAILABLE
Columbia		Yes	
Jefferson		Yes	
Lincoln		Yes	
McDuffie		Yes	
Richmond		Yes	

Macon Service Area:

Residence/ Work County	Aetna U.S. Healthcare	Blue Choice	Kaiser Permanente
Baldwin	NOT AVAILABLE	Closed to new members	NOT AVAILABLE
Bibb		Yes	
Bleckley		Yes	
Houston		Yes	
Jones		Yes	
Laurens		Closed to new members	
Peach		Yes	
Pulaski		Yes	
Twiggs		Yes	
Wilkinson		Yes	

Savannah Service Area:

Residence/ Work County	Aetna U.S. Healthcare	Blue Choice	Kaiser Permanente
Bryan	NOT AVAILABLE	Yes	NOT AVAILABLE
Bulloch		Yes	
Chatham		Yes	
Effingham		Yes	
Liberty		Yes	

Results of Customer Satisfaction Surveys

The following section compares your level of satisfaction among the HMO options offered under the SHBP—by various categories. All the responses are from SHBP members, including state employees, teachers, school service employees and retirees. Surveys were sponsored by the respective Plan option administrator and results were generally compiled by independent research firms. PPO satisfaction ratings are not available for this year's comparison since one full Plan year had not elapsed when the data were compiled. High Option ratings are not available since it is an indemnity plan without managed provider networks.

Quality of Care:

Are you satisfied with the overall quality of care and services received from your health care providers?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	88%	Satisfied	89%	Satisfied	89%
Dissatisfied	5%	Dissatisfied	3%	Dissatisfied	5%

Total % of responses does not equal 100%. We only included responses that clearly indicated the level of satisfaction you expressed

Provider Courtesy:

Are you satisfied with the friendliness and courtesy shown to you by providers?

Aetna US Healthcare		BlueChoice		Kaiser Permanente	
Satisfied	91%	Satisfied	93%	Satisfied	92%
Dissatisfied	3%	Dissatisfied	2%	Dissatisfied	2%

Customer Service Courtesy:

Are you satisfied with the friendliness and courtesy shown to you by customer service representatives?

Aetna US Healthcare	Blue Choice	Kaiser Permanente
Satisfied 84%	Satisfied 88%	Satisfied 88%
Dissatisfied 7%	Dissatisfied 5%	Dissatisfied 6%

Access to Care:

Are you satisfied with the geographic accessibility of the physician's office?

Aetna US Healthcare	Blue Choice	Kaiser Permanente
Satisfied 88%	Satisfied 90%	Satisfied 87%
Dissatisfied 5%	Dissatisfied 4%	Dissatisfied 6%

Customer Service Problem Solving:

Are you satisfied with the ability of customer service representatives to provide specific directions or answers to any claim issues or problems you may have?

Aetna US Healthcare	Blue Choice	Kaiser Permanente
Satisfied 67%	Satisfied 72%	Satisfied 65%
Dissatisfied 22%	Dissatisfied 17%	Dissatisfied 18%

Waiting Times:

Are you satisfied with the length of time you had to wait between making an appointment for routine care and the day of your visit?

Aetna US Healthcare	Blue Choice	Kaiser Permanente
Satisfied 75%	Satisfied 79%	Satisfied 76%
Dissatisfied 19%	Dissatisfied 12%	Dissatisfied 17%

Customer Service Performance:

Are you satisfied with the overall performance of customer service representatives?

Aetna US Healthcare	Blue Choice	Kaiser Permanente
Satisfied 71%	Satisfied 77%	Satisfied 78%
Dissatisfied 15%	Dissatisfied 9%	Dissatisfied 10%

Overall Satisfaction:

All things considered, are you satisfied with your current health plan?

Aetna US Healthcare	Blue Choice	Kaiser Permanente
Satisfied 81%	Satisfied 84%	Satisfied 90%
Dissatisfied 14%	Dissatisfied 12%	Dissatisfied 6%

Enrollment Information

Enrolling Yourself

If you're eligible to participate in the State Health Benefit Plan (SHBP), you can become a member by enrolling. The first opportunity you have to do that is within 31 days from your hire date.

To find out if you're eligible, read the rules on eligibility. They're set out in detail in either of two booklets—*State Health Benefit Plan* or *HMO Member Handbook*. Depending on the option you select, you should receive one of these two booklets. Both are available from your personnel/payroll office.

If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. If you don't, you can still sign up later—under either of these circumstances:

- During an *open enrollment period*. This occurs once a year, and lasts for 30 days. It falls between April 15 and May 31; coverage requested at that time takes effect on July 1.
- If you or your spouse or eligible dependent(s) lose or discontinue health benefit coverage through Medicaid, Medicare, or other group coverage through employment. If this happens, you must file a request to enroll in coverage no later than 31 days following the event. (Attach a letter from Medicaid, Medicare, or the spouse's or former spouse's employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.)
- If you acquire a new dependent as a result of marriage, birth, adoption, a qualified medical child support order (QMCSO) or certain other changes in family status, you may be able to enroll yourself and your dependents, provided you request enrollment no later than 31 days following the event. Documentation may be required.
- If you lose coverage as a result of divorce, you may be able to enroll yourself and your eligible dependents, provided you request enrollment no later than 31 days following the loss of the other coverage. (Attach a letter from the former spouse's employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.)

You will have two major choices to make when you sign up for SHBP membership: the coverage option you want (Standard PPO Option, PPO Choice Option, High Option, and HMO Option—regular, or consumer choice; all are described briefly in this booklet); and the coverage type you want (single or family coverage). For details on single versus family coverage, please see the SHBP booklet or HMO Member Handbook.

Note: If you sign up for one of the HMO options, you must complete an *Enrollment Supplement for the Health Maintenance Organizations* form, indicating your selection of a primary care physician.*(See page 41.) In some cases, receipt of your HMO ID card could be delayed if a primary care physician selection is not received by the HMO. During open enrollment, most eligible employees can designate primary care physicians online.

**State agency and school system personnel have online access to a Web site for open enrollment changes. See your personnel/payroll office or refer to your Personalized Change Form or Option Statement.*

The SHBP booklet or HMO Member Handbook also will tell you about the rules that govern your participation and that of your eligible dependents. Read the appropriate one, thoroughly, and remember: The HMO options have some rules of their own, but they also are subject to all State Health Benefit Plan rules and provisions. In other words: If an eligibility or participation rule set up by an HMO conflicts with an SHBP rule, the SHBP rule will govern.

Enrolling Your Dependents

When you enroll yourself in the SHBP, all of your dependents who are eligible at the time also will be enrolled—if you choose family coverage, and if you list them on your *Membership Form* or at the Web site.

If you have single coverage and later acquire one or more dependents and wish to change to family coverage, you must—within 31 days—file a *Membership Form* with the SHBP, requesting coverage of the new dependent(s). Also, there are some requirements for *reporting* to the SHBP on the changing or continuing status of various dependents—dependents with disabilities, in particular, and dependents over age 19 who qualify for coverage on the basis of full-time attendance at an accredited school. Benefits cannot be paid on behalf of these dependents unless their status is verified based on the SHBP's rules; so the reporting process can be very important to you.

For details—and for more information on other aspects of dependent eligibility—please see the SHBP booklet or HMO Member Handbook.

Changing Your Coverage

Changing your Coverage Option

You have a number of choices for coverage under the SHBP, which are described in this Guide: the Standard PPO Option, the PPO Choice Option, the High Option, and the HMO Options (if you live or work within the HMO's service area).

If you want to change from one option to another, you can do that during an open enrollment period. You also can change options under other, limited circumstances, by filing a *Membership Form* with the SHBP prior to or within 31 days after one of these events:

- If you are enrolled in an HMO and either you, your spouse, or enrolled dependent becomes ineligible to participate in that HMO by transferring work location or changing residence, you may change to any available option or discontinue coverage.
- If you are enrolled in an HMO and that HMO goes out of operation. The time limit for filing a *Membership Form* is 31 days. If you don't file within that time, you'll be enrolled automatically into Standard PPO Option coverage.
- If you, your spouse, or former spouse loses other coverage due to a change in employment status affecting eligibility for other group coverage, or as the result of divorce, you may change between single and family coverage and to any available option. You must file your request no later than 31 days following the event. (Attach a letter from the employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.)
- You may change to any available option or discontinue coverage when you, your spouse or enrolled dependent changes residence to an area that is not serviced by the option in which you are enrolled. The request must be filed within 31 days of the event. Documentation of the change in residence may be required.
- You can change from any HMO option to either PPO Option or to High Option or from either PPO Option to the High Option upon determination by the Administrator that a court or administrative order is a qualified medical child support order for a natural child of a member, provided the child lives outside the HMO or PPO service area. A change to either the PPO Option or High Option shall not be subject to any timely filing requirements.
- If you retire, and qualify for a retirement annuity, you can change to any available option at the time of retirement. The time limit for filing a *Retirement/Surviving Spouse Form* is 60 days after your retirement date.

Keep this in mind: Once you've chosen an option and registered your decision by filing the proper form(s) with the SHBP, you can't just *drop out*. Your coverage selection constitutes a one-year contract. You must remain in your selected coverage until the next open enrollment period, unless a qualifying event permits a change, as described here.

Changing Your Coverage Type

There are two types of coverage under the SHBP—single coverage or family coverage.

When you enroll, you choose one or the other. Thereafter, you can change your coverage type only during an open enrollment period or when you have a qualifying change in family status as described below:

- You may change to single coverage or discontinue coverage when you, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid. You must submit your request on the proper forms no later than 31 days after the event. Documentation will be required.
- You may change to single coverage or discontinue coverage if your spouse or your only enrolled dependent's employment status changes and that change affects their eligibility for other group coverage. You must submit your request on the proper forms no later than 31 days after the event. Documentation will be required.
- You may enroll, change to single coverage, or discontinue coverage when you acquire eligible dependents through marriage, birth, adoption or legal guardianship.
- You may change to single coverage or discontinue coverage if your marriage results in dual health benefit coverage.
- You may enroll or change coverage type if you or your spouse are activated into military service.
- You may enroll, change to single coverage, or discontinue coverage when your spouse makes an open enrollment election under a qualified employer provided plan and that change creates an overlap or break in health coverage because the other health coverage has a different plan year than the SHBP. You must submit your request on the proper forms no later than 31 days after the event. Documentation will be required.

If you sign up for the HMO Option, you must complete an Enrollment Supplement for Health Maintenance Organizations form, indicating your selection of a primary care physician. (In some cases, receipt of your HMO ID card could be delayed if a primary care physician selection is not received by the HMO.)

- You also may change to single coverage within 90 days following the loss of all enrolled dependents through divorce, death, legal separation, or when your only dependent no longer meets the definition of an eligible dependent. (The effective date of the change in coverage will be the first of the month following receipt of the request.)
- You may also change to single coverage if a qualified medical child support order (QMCSO) resulting from divorce, legal separation, annulment, or change in legal custody requires your former spouse to provide health coverage for all of your enrolled dependents. Documentation of the court order and the effective date of coverage under another health plan will be required. The request must be filed within 90 days following the court order. (The effective date of the change in coverage will be the first of the month following receipt of the request.)

Notes: In order for a requested Plan change to qualify, you must file a completed *Membership Form* with the SHBP no later than 31 days after the event unless noted otherwise. Eligibility rule changes are effective July 1, 2001.

How to Enroll or Change

If you want to enroll or change your option or your coverage type, the first step is to get the proper form(s). Do this at your personnel/payroll office, or at the office that normally handles your payroll deductions. During open enrollment most employees can do these transactions on the Web site without forms.

Complete the necessary forms if you are not using the Web site. If you select an HMO, be aware that there's an *Enrollment Supplement for Health Maintenance Organizations* form you must complete, indicating your selection of a primary care physician. Then file the completed form(s) at the office where you got them (or as otherwise instructed by your employer.)

Timely Filing Is Important.

Remember these deadlines:

- For enrolling at time of employment, you must sign and file within 31 days of your employment date.
- For enrolling or changing during an open enrollment period, you must enter your change(s) at the appropriate Web site or submit Plan paperwork during the appropriate period.
- For changing an option or your coverage after a qualifying event, you must file prior to the event or not later than 31 days after the event occurs. (Except as noted.)

Remember: All forms must be filed with the SHBP through your personnel/payroll office. Even if you're enrolling in an HMO, file your forms with the SHBP; the Plan will forward the information to the HMO. **Special Opportunity:** During open enrollment, Web sites are available to make changes, including PCP election and dependent updates.

Appeals

HMO option members have two avenues through which to file an appeal, depending on the issue requiring review.

For Plan Eligibility

If you receive an eligibility denial, you must file your appeal directly with the SHBP. You have three levels of appeal available. Common examples of eligibility determinations made by the SHBP include student status, stepchild and adoption confirmation, and the availability of Plan membership for dependents.

For Benefit Claims

If you are a member of an HMO and your claim is denied, then you must file your appeal directly with your HMO. Generally, an HMO will have more than one level of appeal should your first attempt prove unsuccessful. However, once all levels of appeal are exhausted, the HMO's decision is your final administrative remedy. The State Health Benefit Plan does not have the authority to overturn an HMO's decision to deny coverage based on their benefit contract with you. Common examples of appeals processed by your HMO include non-covered benefits, unpaid doctor and hospital bills, and claims for out-of-network services.

PPO Option and High Option members also have available a structured appeal process for Plan eligibility and claims. For more information on eligibility and claim appeals, see the SHBP booklet or HMO Member Handbook.

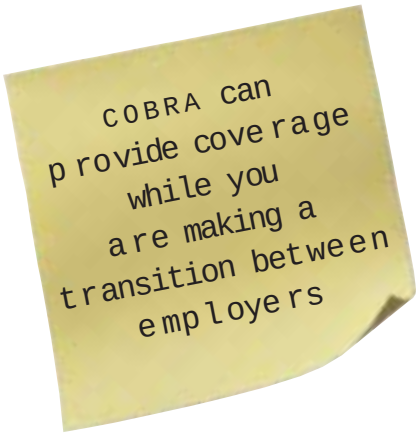
Termination of Coverage

Generally, you can participate in the SHBP for as long as you qualify for membership in any one of the various options set out in the SHBP booklet or HMO Member Handbook and in the UPDATERs. When you no longer qualify, your coverage will end.

You no longer qualify for active member coverage after one of these events:

- If you resign or otherwise terminate your employment with the state or local school system.
- If you are laid off resulting from a formalized plan to reduce staff.
- If you have a reduction in hours and are no longer a full-time employee of the state of Georgia, or of an agency or a county that participates in the Plan, or of a local school system. Minimum hours required for full-time status vary depending on whether you are a state employee, teacher, public school employee, or county employee.

Note: For the first three events, coverage terminates at the end of the month following the last payroll deduction for coverage.



Termination of Coverage (cont.)

- If you fail to return to active employment after an approved leave without pay.
- If you fail to pay the proper premiums on a timely basis (for example, while you are on a leave of absence without pay).

If any of these disqualifying events happen, you may qualify for *Temporary Extended Coverage* (TEC) under the provisions of COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986), a federal statute. COBRA provides for up to 18 months of continuous coverage for you, or for up to 36 months for each enrolled dependent or qualified survivor. An additional 11 months of coverage may be provided to an extended beneficiary who is disabled while covered under COBRA and meets the definition of disability as determined by Social Security. For COBRA coverage you must pay the full premium plus an administrative fee. Your TEC benefits can end early if you fail to pay your premiums on a timely basis; if you enroll in another group health care plan or become eligible for Medicare; or if the SHBP is terminated.

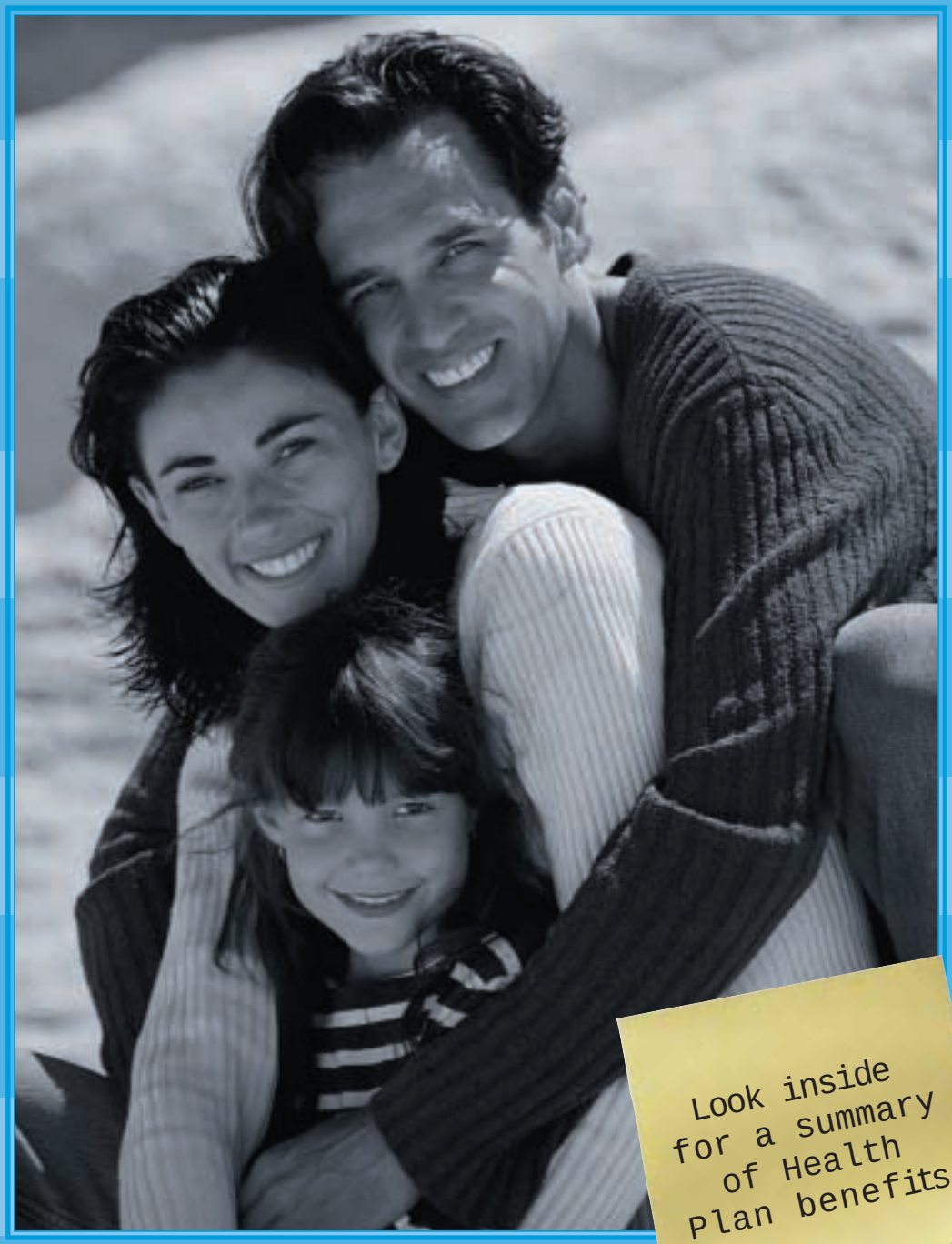
Before your TEC period runs out, you will be able to take advantage of a conversion privilege—a chance to convert your SHBP coverage to a plan of individual, direct-pay health care insurance. The PPO Options, High Option, and the HMO Options are subject to conversion. See your SHBP booklet or HMO Member Handbook.

Note: The PPO Options and High Option also contain a special disability provision, unrelated to COBRA, that can provide for continuation of benefits when an SHBP member's participation is terminated because he or she is totally disabled. See your SHBP booklet.

In addition to temporary extended coverage under the provisions of COBRA, an SHBP member may qualify for extended coverage under state law. Examples of coverage extension available under state law include coverage for retirees and surviving spouses. See the SHBP booklet for more details.

Penalties for Misrepresentation

If any SHBP participant misrepresents the facts when applying for coverage, change of coverage, or benefits, the SHBP may terminate the person's participation (along with that of his or her dependents), and seek legal recovery of any money paid out by the SHBP as a result of the misrepresentation.



Look inside for a summary of Health Plan benefits

Georgia Department of Community Health
Division of Public Employee Health Benefits